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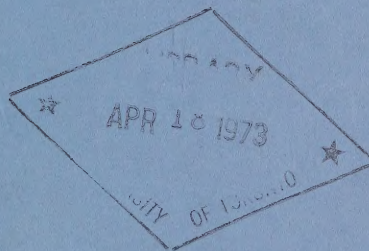
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ENQUIRY INTO THE  
HEALTH CARE SYSTEM  
IN THE  
MINISTRY OF  
CORRECTIONAL SERVICES

*Report*



REPORT TO THE MINISTER



**E. H. BOTTERELL**  
(COMMITTEE OF ONE)






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REPORT  
TO THE  
MINISTER

E.H. BOTTERELL, M.D.  
(COMMITTEE OF ONE)



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REPORT  
to the  
HONOURABLE C.J.S. APPS  
MINISTER OF CORRECTIONAL SERVICES

from  
E.H. BOTTERELL, M.D.

Research Associate

Dr. Gordon H. Josie

Consultants

Miss Shirley Smale, R.N.  
Dr. F.C.R. Chalke  
Dr. W.E. Boothroyd  
Dr. D.W. Lewis





REPORT TO THE MINISTER  
MINISTRY OF CORRECTIONAL SERVICES

PREFACE

The Honourable C. J. S. Apps, Minister of Correctional Services, decided upon a one-man committee to study the system of delivery of health care in the Ministry with a view to providing better health care and treatment for each individual, student in a training school or inmate of an adult institution, who is the responsibility of the Ministry. Upon the recommendation of the College of Physicians and Surgeons of Ontario the writer was invited to serve as a one-man committee and agreed with the understanding that consultants from the dental profession and from the nursing profession would be appointed for the "Committee". Their reports would be attached to mine as appendices. As well, other consultants from specialized fields of medicine could be appointed by the Minister upon the recommendation of the "Committee". In the event, appointments of additional consultants in psychiatry and drug abuse, including alcohol, were made by the Minister after consultation and with the agreement of the Ministry of Health. A research associate was also agreed upon.

I am extremely grateful and deeply appreciative of the magnitude of the effort made by my colleagues and of the quality of their indispensable individual contributions. I refer to





Dr. Gordon Josie, Miss Shirley Smale of McMaster University School of Nursing, Dr. D. W. Lewis of the Faculty of Dentistry at the University of Toronto, Dr. Wilfred E. Boothroyd of the Addiction Research Foundation and Dr. F. C. Rhodes Chalke, Professor of Psychiatry and Associate Dean of Medicine, University of Ottawa.

To Professor Harding le Riche, Professor of Epidemiology, School of Hygiene of the University of Toronto; Professor Robert Steele, Head of the Department of Community Health and Epidemiology, Queen's University; Professor Arthur Kraus, Department of Community Health and Epidemiology, Queen's University, and their research associates, I express on behalf of the Ministry as well as for myself, appreciation of their expenditure of time and thought in developing health data from the existing medical records they studied at a sample of training schools and adult institutions.

The magnitude of my indebtedness to so many of my professional colleagues in medicine and nursing makes inadequate my sincere thanks which I now proffer and record.

To discover at first hand the whimsical wit, and remarkable qualities of Dr. Gordon Josie as a research worker in health has been one of the great pleasures of this project for me. Dr. Josie has been the anchor man of the group and because of him, the contributions of us clinicians have been broadened and deepened. With all this group it required Mrs. Sylvia Wilson, our project secretary, to coordinate our efforts and produce this report.

My warmest personal thanks go to each member of this group.

I am grateful to Dr. John Deutsch, Principal of Queen's University, for his encouragement to me to undertake this endeavour.

*Harry Botterell*

EHB/sw

E. H. BOTTERELL, M.D.

Toronto, Ontario  
November 28, 1972.

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## I. INTRODUCTION

### 1. Origin and Terms of Reference of the Enquiry

A coroner's jury investigating the death of an inmate, recommended that an enquiry be made into the present system of medical examination and treatment in correctional institutions. The Minister of Correctional Services followed through with a specific recommendation approved by Order-in-Council OC-390/72 of 26th January, 1972, (Appendix 1), that Dr. Harry Botterell be appointed "...to examine the adequacy and effectiveness of the present system of medical examinations and treatment in Correctional Institutions in Ontario".

It is to be noted that -

- (1) both the adequacy and effectiveness of the services are to be considered, and
- (2) the enquiry does not include consideration of the circumstances of the inmate's death; these have already been the subject of a specific enquiry.

The Minister, in a letter to Dr. Botterell dated 28th January, 1972, (Appendix 2), confirmed his appointment on the nomination of the College of Physicians and Surgeons of Ontario as a one-man committee of enquiry\*. The Minister asked Dr. Botterell "...to make a broad enquiry into the entire health care system of the Department". The appointment of Dr. Botterell to enquire

\*As Dr. Botterell was a one-man committee the Report is his alone but it was written generally as that of "The Committee."

into the Ministry's health care system was made public in a News Release dated 31st January, 1972 (Appendix 3).

In subsequent discussion with the Minister it was agreed that this study was to cover the whole health care delivery system, including medical, dental, nursing and related health services and that the emphasis was to be on the possibilities for improving the system rather than on particular deficiencies or defects of present arrangements. The focus was to be on the health needs of persons detained in correctional institutions. It was further agreed that the intention was to include the training schools in the enquiry. The scope of the enquiry was made clear in a memorandum from the then Deputy Minister to superintendents of all institutions, including jails and training schools (Appendix 4). The memorandum, dated 9th February, 1972, stated that the Minister has asked Dr. Botterell "...to enquire into the provisions for the delivery of health care services at all levels throughout the Department". The memorandum also specified that "These broad terms of reference should be brought to the attention of all medical nursing and dental personnel, members of allied health professions and paramedical personnel" and further "...anyone wishing to bring matters to Dr. Botterell's attention is encouraged to do so by submitting material directly to him, at Queen's University, Kingston, Ontario, or through the Director of Medical Services, the Executive Director, Professional Services Division, or the Executive Director, Institutions Division". All personnel of the Department were

"...requested and authorized to bring forward to Dr. Botterell information they judge appropriate to this enquiry or information requested by the committee".

The scope of this enquiry is comprehensive in encompassing all aspects of health care services in all institutions and training schools but it does not extend to any assessment of the correctional system as such unless there is a clear relevance to health care.

## 2. Purpose of the Ministry

The Statement of Purpose of the Department (Annual Report 1971) declares in part that, "The main purposes of the Department... are (1) to carry out the legal duties imposed upon the Department by the courts for the protection of society, and (2) to attempt to modify the attitudes of those in its care and to provide them with the kind of training and treatment that will afford them better opportunities for successful personal and social adjustment in the community. All of our programs must be designed with prime emphasis on these purposes and carried out in such a way that they are in consonance with each other".

### Treatment and Health

No other reference occurs in the Statement of Purpose to the health either of students in training schools or inmates of jails and adult correctional institutions. The Committee takes the word "treatment" to include all treatment - medical, psychiatric, dental,



nursing, pharmacologic, psychological and social - designed to achieve a state of health in the sense of the definition of "health" by the World Health Organization - "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity".

The Annual Report of the Minister (1971) under 'Medical Services' states "The prime responsibility of this branch is the medical welfare of residents held in the care of the Department... The services provided are similar to those available in the community...".

Statement of Purpose of the Department:  
Research

The last paragraph of the Statement of Purpose of the Ministry is of the greatest importance: "We lay great stress on research, and our operations are guided as much as possible by research findings; inherent in all of our operations is the principle that what serves no useful purpose should be discarded".

3. Objectives of the Study of the Health Care System

Having in mind the terms of reference of this enquiry and the purpose of the Ministry, it may be stated that the objectives of this study are;

(a) To establish whether or not -

- (i) the system of health care delivery may reasonably be expected to provide decent, adequate and effective health services for wards in training schools and elsewhere; and inmates in adult institutions;

- (ii) the system of health care makes the maximum possible contribution to students and adult inmates in their efforts to rehabilitate themselves while in Ministry institutions;
  - (iii) the system of health care has built into it research facilities providing for the prospective evaluation of health care services by scientifically designed research;
  - (iv) the system is sufficiently flexible and adaptable to meet changing circumstances and the advances of health services;
  - (v) the system of health care delivery ensures that human experimentation is undertaken only after appropriate critical review and documentation.
- (b) To make recommendations designed to improve the health care delivery system and to eliminate or minimize any deficiencies in the system with respect to the foregoing functions (a).

#### 4. General Method and Procedures

##### (a) One-man committee with consultants

The Minister expressed an urgency about the completion of this enquiry. It seemed appropriate to proceed at least initially on a relatively informal and unstructured basis using a variety of methods concurrently. From the outset the collaboration and advice of consultants in certain specialized areas was recognized as essential. Gordon H. Josie, Sc.D., M.P.H., M.Sc., latterly Senior Scientific Advisor (Health Services) Department of National Health and Welfare, undertook to provide advice and assistance on research aspects of the project. Dr. Josie has also contributed largely in the development of the various components of the investi-

gation through the Committee's office in the Ministry at Toronto.

There is general recognition (e. g. by the Ontario Council of Health) that there are three primary health professions - medicine, dentistry and nursing. Consultants were therefore obtained in nursing, Miss Shirley Smale, R. N., M. P. H., School of Nursing, McMaster University; in dentistry, D. W. Lewis, D. D. S., D. D. P. H., M. Sc. D., Professor and Chairman, Department of Community Dentistry and Head of Biometrics Section, Faculty of Dentistry, University of Toronto; in psychiatry, Dr. F. C. Rhodes Chalke, Professor of Psychiatry and Associate Dean of Medicine, University of Ottawa, fortunately was available to consult on this enquiry. Drug abuse was recognized as a special problem and Dr. Wilfred E. Boothroyd, Senior Medical Consultant, Addiction Research Foundation, joined the Committee as a consultant in drug addiction. It was agreed that Miss Smale, Drs. Chalke, Lewis and Boothroyd, would prepare reports for the Committee which would be sent to the Minister as appendices to the Committee Report\*.

Family physicians serving as medical officers were consulted in the course of the visits by the Committee to correctional centres, jails and training schools, as were nurses. Additionally, Dr. Richard Milne, a family physician, teacher and former jail

\*Dr. Botterell was a one-man committee, nevertheless he worked in close collaboration with the consultants throughout the course of the enquiry. The consultant reports are in Appendices A,B,C and D.

physician, was consulted and gave the Committee most valuable advice. Representative psychologists, psychometrists, social workers, and one criminologist were also consulted.

(b) Main office interviews

A series of interviews with the Deputy Minister and senior officers of the Main office of the Ministry at Toronto provided orientation to departmental policy, organization and administration and an insight into their views concerning correctional trends and problem areas relevant to health services. (Lists of Ministry officers and others interviewed are given in Appendix 5.)

(c) Comments and views of health services  
professional staff

Although the Deputy Minister had requested all personnel to provide relevant information\*, there was little direct response to this suggestion and it seemed advisable to seek specifically the views, comments and opinions of health services staff on ways of improving the health care delivery system. Accordingly, on 28th April, with the Deputy Minister's warm approval, a letter was sent on a confidential basis to professional staff of the Ministry directly involved in health care, including specifically, physicians, psychiatrists, nurses and dentists. (See Appendix 6.)

(d) Other professional services

In view of the relevance to health services of certain other areas of professional responsibilities within the Ministry, the

\*See Page 2 and Appendix 4.



views were sought of those concerned and a letter was sent on 9th May, 1972, to the Directors of Psychology, Chaplaincy Services, Food Services, After-care Services, Education, Social Work, Recreational Services and Research. Each Director was asked for his views on ways of improving the health services and was invited to seek the views of staff under his professional direction (Appendix 7). These Directors were also interviewed to obtain, on a direct and informal basis, their views and opinions.

(e) Visits to institutions and training schools

An important source of information and perhaps the major contributor to this enquiry has been derived from the visits by the Committee and the Consultants to the jails, other adult correctional institutions and training schools and the interviews with the superintendents, correctional staff, physicians, dentists, nurses, other allied health professional staff members and some inmates and students.

The Committee, usually accompanied by one or more of the consultants, visited most of the correctional centres, adult training centres and training schools, as well as both clinics, the Toronto, Hamilton, Kenora and other large jails, Quinte Regional Detention Centre and some of the smaller jails throughout the province. The only notable exceptions are the forestry camps and Project D.A.R.E., the Monteith Correctional and Adult Training Centres and Burtch Correctional Centre. The Monteith Correctional Centre was, however, visited by the Consultant in

Drug Addiction and Burtch by the Dental Consultant. On the other hand, such major centres as at Guelph and Brampton, the Grandview Training School and Reception and Diagnostic Centre at Galt, the Clinics, the Sprucedale Training School and White Oaks Village at Hagersville and the Toronto Jail, were visited in most instances by all the consultants. A detailed list of the institutions and schools visited is given in Appendix 5.

(f) Health Services Questionnaire

It was desirable to have certain basic data about health resources and services on a reasonably uniform basis for each institution or school to provide a factual background for assessment of the health care delivery system. A questionnaire was therefore devised and sent with covering letter dated 28th April, 1972, to the superintendent of each institution and school. (Copies of the Questionnaire and letter are shown in Appendix 8.) Questionnaires were received from every Ministry institution and school except one adult training centre and two jails.

(g) Health Personnel Inventory

In addition, a health personnel inventory form was sent to each person employed or engaged solely or primarily for health care duties (Appendix 8). Data were also obtained at the Main Office and during institutional and school visits concerning the employment of psychologists, psychometrists, social workers

(psychiatric and medical) and of various kinds of technicians and auxiliaries.

(h) Medical record field studies

Early in the investigation it was found that there was a lack of statistical information about the health status of the inmates of the correctional institutions and of students in training schools and concerning the kinds of illnesses for which they sought medical care and the types of health services provided. It was decided, therefore, to have field studies conducted in selected institutions and training schools to obtain at least illustrative data as quantitative answers to the questions: (a) What was the complaint or symptoms or health problem of student or adult inmate? and (b) What was the response of the health staff? The first question was to be answered in terms of a list of "Selected Diseases, Symptoms and Ill-defined Conditions" and the second in terms of a "Type of Service" list. The information was to be obtained from the Medical Status Summary Form 9801 and its supplement, the Treatment Record (continued) Form 9802.

These studies were carried out by a team under the direction of Professor Harding le Riche, Head of the Department of Epidemiology and Biometrics, School of Hygiene, University of Toronto, and a team under the direction of Professor Robert Steele, Head of the Department of Community Health and Epidemiology, Queen's University and Professor Arthur Kraus of that department. An

attempt was also made to get an indication of the frequency of contacts of inmates with the medical staff. The forms and classification and code systems used are shown in Appendix 9.

These statistical surveys have been of special assistance because the Committee visited each of these schools and correctional institutions on one or more occasions. The data were supplemented or elucidated by information obtained at these visits and others. Specifically, Professor Chalke, Miss Smale and Dr. Botterell sat in as observers at the sick parade at Guelph Correctional Centre conducted by the medical staff; Miss Smale joined the nurses in their activities including nurses' sick parade; in Millbrook Correctional Centre, Dr. Botterell and Dr. Chalke were observers at the physician's sick parade, including that day's admissions; Miss Smale, on a separate date, observed the nurse's sick parade at Millbrook Correctional Centre.

In the course of the Committee's visits, with the exception of one training school, one correctional centre, one adult training centre and the Alex G. Brown Memorial and Neuro-Psychiatric Clinics, private conversations with students or inmates were conducted by the Committee.

(i) Financial and Personnel data

It seemed essential to have an idea of the current cost of health services in the Ministry and the break-down of costs. An enquiry was directed to the office of the Chief Accountant to obtain



expenditures on medical, psychiatric, dental and other health services for the whole Ministry and for institutions and schools individually. Information was also obtained from the Director of Personnel and the Director of Medical Services concerning the employment of health services staff, and from the Director of Psychology concerning psychologists and psychometrists, and from the Director of Social Work concerning social workers. (See Appendix 10.)

(j) Other health agencies and organizations

Visits were made on an informal basis to discuss with appropriate officers of the Ministry of Health and certain universities, hospitals and clinics, their possible contribution to the improvement of correctional health services through provision of training, research, treatment or consultant services.

(Appendix 5.)

(k) Length of stay studies

In view of the evident importance of length of stay of inmates and students in the institutions and schools of the Ministry, it was decided to supplement information available at the Main Office by special sampling studies of inmate records. (Appendix 11.)

(l) Other sources of information

In addition to the variety of methods used in this investigation as outlined above, attention was also given to relevant reports, records and statistics provided by officers of the Ministry, and obtained elsewhere.

## II. MINISTRY AND INSTITUTIONAL ORGANIZATIONS

### 1. Main Office

The overall administrative plan of the Ministry has been essentially tripartite in its recognition of

- Jails
- Correctional institutions for adults
- Training schools for wards - children.

The administration of adult institutions has now been unified. The tripartite concept is, however, particularly appropriate to the health services which have been studied using in broad and flexible fashion the tripartite grouping but also recognizing (1) potential health service inter-relationships among all Ministerial institutions on a geographical basis, (2) a potential common shared relationship with a university, a regional academic health sciences complex, a satellite health centre, or a university affiliated Ontario Psychiatric Hospital.

Health services must be provided in three main areas:

- (1) To students in training schools, ranging in age from 8 to 16 years - 1,379 on March 31, 1971 (1,179 on April 2, 1972);
- (2) To inmates of adult correctional centres - 2,682 on March 31, 1971 (2,420 on April 2, 1972);
- (3) To adults moving in and out of jails - 80,755 in 1971 (population count 1,958 on March 31, 1971; 1,720 on March 26, 1972).

Differences exist between the special needs and health problems of jails and adult correctional centres reflecting particu-

larly population dynamics. The jails have a large number of admissions and discharges and correspondingly short stay. The overall average stay was less than 10 days in 1971 with substantial numbers and proportions staying less than a week. This is in contrast to correctional centres with an average stay of about two months and much less population movement. The jails have over 80% of those admitted or under care during the year in Ministry institutions and schools but only one-third of the population at any one time (Table 1, Page 15). The correctional centres (including adult training centres) have only 13% of those under care during the year but 45% of those in custody on any day.

With only a few major exceptions, e. g. Toronto Jail, Guelph, Burwash and Mimico Correctional Centres, the population at any time in one institution or school is small, generally less than 100 inmates or students. One other jail, two correctional centres, one adult training centre and four training schools have an average population of between 100 and 200. While Ministry policy (Annual Report 1971, Page 7) for good reason emphasizes the desirability of small institutions with a maximum capacity of 200 for adults and 125 for schools, this relatively small population introduces problems in the economical supply of effective health services from the standpoint of both manpower and facilities, particularly health manpower.

TABLE 1

BASIC DATA ON POPULATION MOVEMENT

MINISTRY JAILS, ADULT CENTRES AND TRAINING SCHOOLS

(During the year ended March 31, 1971 or as specified)

Item and Period or Date	Correc- tional Centres	Adult Training Centres	Total*	Jails	Training Schools	Grand Total
1. In custody (residence) April 1, 1970	2,393	308	2,701	1,767	1,404	5,872
2. Committed (admitted) during year	8,897	821	9,718	76,284	1,450	87,452
3. Total under care during year	11,417	1,135	12,552	80,755	3,599	96,906
4. In custody (residence) March 31, 1971	2,367	315	2,682	1,958	1,379	6,019
5. Population count April 2, 1972 (Jails March 26)	2,103	317	2,420	1,720	1,179	5,319
6. Capacity April 2, 1972	2,989	384	3,373	2,578	1,641	7,592
7. Approx. average stay in the institution or school	2 months	3 months		10 days	6-8 months	
8. Transferred to other institutions during year	1,202	88	1,290	13,141		

Percentage Distributions

Committed (2)	10.17	0.94	11.11	87.23	1.66	100.00
Total under care (3)	11.78	1.17	12.95	83.33	3.71	99.99
Population count (5)	39.54	5.96	45.50	32.34	22.17	100.01
Capacity (6)	39.37	5.06	44.43	33.96	21.61	100.00
Transfers (% of committed)	13.51	10.72	13.27	17.23		

\*Includes Clinics and Forestry Camps

Sources: Annual Report 1971 Statistical Section, pp. 37-51 (Items 1,2,3,4,8)  
 Ministry - Adult Institutions Count Sheet, April 2, 1972 (Items 5,6)  
           - Juvenile Schools Count Sheet, April 2, 1972 (Items 5,6)  
           - Monthly Count Summary, March 26, 1972 (Items 5,6-Jails)  
 Sample studies of inmate records (Appendix 11) (Item 7)



Similarities, as well as differences, in needs for health services also exist between jails and adult correctional institutions for some inmates may be transferred from correctional institutions to jails for security reasons; some inmates may spend months on remand in jails; by Ministry design some inmates may serve a sentence of months in jails.

Training schools constitute a highly specialized problem in health, education, welfare and rehabilitation. To think, for example, of the Cecil Facer School on the one hand, and of Millbrook Correctional Centre on the other hand, is to think of two completely disparate entities. Training schools have a young population of children and teenagers who stay relatively long periods - 6-8 months in a school.

## 2. Health services organization - Main Office

The organizational pattern for the three primary health professions (Report of Minister, Page 12, 1971) covers only medical services. At Main Office the Director of Medical Services has reported to the Executive Director of Professional Services. There is no nurse consultant, supervisor or director of nursing responsible professionally for some 84 full-time and part-time nurses. There is no consultant or coordinator of dentistry.

Among the allied health professions there has been a Director of Social Work and Director of Psychology reporting to the Executive Director of Professional Services.

It is noteworthy that the Directors of Recreation, Food Services, Chaplaincy, Education, After-care Services and Research, also have been the responsibility of, and reported to, the Executive Director of Professional Services. Under the new Ministry organization, the present full-time Directors of Social Work, Psychology and Chaplaincy, are to be replaced by consultants who will work on a part-time basis and will report to a Coordinator of Treatment and Training; the Director of Medical Services has become the Medical Advisor also reporting to the Coordinator of Treatment and Training.

Whatever the job descriptions may record, the Committee believes that in practice the Directors of Medical Services, Psychology and Social Work have been regarded primarily as consultants and recruiters of professional personnel. Communication and consultation between these directors and the executive directors in the Department was widely held to require improvement.

### 3. Health services organization - Institutions

The existing role of a superintendent of a training school, a jail and of an adult correctional centre is held throughout Main Office and the individual institutions to make the superintendent personally responsible for the custody, health and welfare of the students/wards or adult inmates in his charge. This is consistent with regulations under the Department of Correctional Services Act and the Training Schools Act which specifically provide that the

superintendent is responsible for the care of the inmates or wards of his institution or school and in the former regulations the word "health" is included. The pertinent regulations are as follows:

- "3. The Superintendent is responsible for the management of his institution and for the care, health, discipline, safety and custody of its inmates."

(Ontario Regulation 345/69 as amended by O. Reg. 146/71, made under the Department of Correctional Services Act, 1968)

and

- "3. The superintendent is responsible for the management of the school and for the care of its wards."

(Ontario Regulation 25/70 made under the Training Schools Act, 1965)

The Ministry policy and practice do seem to recognize that a medical officer should be responsible for his professional practice. The relevant regulations are:

- "14. The medical officer for an institution shall be a duly qualified medical practitioner who shall control and direct the medical and surgical treatment of all inmates."

(Regulation under Correctional Services Act as above.)

and

- "15. The medical officer of the school shall be a legally qualified medical practitioner who shall control and direct the medical and surgical treatment of all wards."

(Regulation under the Training Schools Act as above.)

While the foregoing seems clear and is comparable to lines of authority for medical services in other organizations, e. g. the Armed Services, there is some difficulty in practice stemming in

part from the relationship of the medical officer and his staff to the superintendent. The medical officer in his responsibility for health facilities and staff engaged in health duties is subject to the direction of the superintendent. The relevant regulations are quite specific:

- "15. The medical officer, subject to this Regulation and the instructions of the superintendent, has complete administrative and professional responsibility for the hospital and clinic and the employees detailed for duty therein. "

(Regulation under the Correctional Services Act as above.)

and

- "16. The medical officer, subject to this Regulation and the instructions of the superintendent, shall have complete administrative and professional responsibility for the infirmary and the employees detailed for duty therein. "

(Regulation under the Training Schools Act as above.)

This problem of a dual responsibility is solved in other organizations by a separate chain of professional communication and responsibility from the medical, nursing and dental staff to headquarters. In the Ministry of Correctional Services the Director of Medical Services is undoubtedly available and willing to be consulted in the event of professional or professional/administrative difficulties. However, he does not have executive or "line" authority.

Consultants in appropriate fields are not available to visit training schools and adult institutions with a view to contributing

to quality control of pediatric, medical, nursing, psychiatric and dental services\*.

The extent to which the Directors of Medical Services, Psychology and Social Work could modify the professional activities in their discipline has varied substantially from institution to institution and, as already noted, the latter two of these directors are to be replaced by part-time consultants. Each individual superintendent, in keeping with his educational and professional background and service experience, exerts a major influence upon the health service in his institution. The Deputy Minister and the Administrators of Adult Male Institutions, Adult Female Institutions, Training Schools and Jails, also have exerted a significant and substantial influence upon professional health services. This administrative influence is unmatched by executive professional responsibility and authority of the Director of Medical Services concerning the professional services involved in the delivery of health care by physicians, nurses or dentists. The Ministry lacks the much needed contributions to quality control of professional services and to departmental health care policies by an Executive Director of Health Services aided by consultants.

A difficulty of at least potential importance pertains to the relationship of unclassified staff members to full-time civil servants.

\*It has been pointed out to the Committee that specialist consultations are, of course, available to the institution doctor in the same manner and to the same extent as these exist in the community in which the institution is located. At Guelph C.C. and Mimico C.C. such specialist services are heavily used.



A regulation under the Public Service Act\* specifies that "No person employed in the unclassified service shall supervise the work of persons employed in the classified service, except with the approval of the Commission". Many of the professional staff particularly are employed on a sessional part-time basis and some are remunerated on a fee-for-service basis and do not fall within the classified service. It would appear that such professional staff members could not supervise the work of correctional officers who might be engaged in health services duties or of nurses, specialized social workers, dental hygienists, or others, on the health services staff who are employed full-time. It is not evident that this situation has posed any practical difficulty so far but the question has been raised with the Committee and some way should be found of overcoming this problem.

\*Regulation 749, Section 5, Subsection (4).

### III. JAILS

#### 1. Basic data about jails and their inmates

There were a year ago 43 jails in Ontario with capacities ranging from 12 for the Fort Frances Jail to 753 for the Toronto Jail. The jails were originally designed to serve municipalities or counties and the jails were taken over by the province from the municipalities in 1968. Three-quarters of the jails are more than 50 years old and over half are more than 100 years old. Less than 10% have been built in the last twenty years.\*

Four small county jails, Belleville, Kingston, Napanee and Picton, were replaced in 1971 by Quinte Regional Detention Centre. This was the first such centre in the Department's program to replace outdated local jails with modern regional facilities. A regional detention centre has been opened this year to serve the Ottawa/Carleton region and another is planned for the Welland/St. Catharines region in 1973.

Although the jail population on 31st March, 1971, was 1,958 and on 26th March, 1972, was 1,720, the jails actually had in custody during the year ended 21st March, 1971, a total of 80,755 persons of whom 76,284 were committed to jail for trial during the year and 64,434 were convicted.

\*Unless otherwise specified data are from the Annual Report of the Minister for the year ending March 31, 1971. Basic data concerning jails and their inmates are given in Appendix 12.

The sex and age distribution of these convicted persons was as follows:

TABLE 2

SEX AND AGE DISTRIBUTION OF PERSONS CONVICTED  
DURING THE YEAR ENDED MARCH 31, 1971

<u>Age Group</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>
Under 16	20	0.03	8	0.23	28	0.04
16 - 20 (under 21)	14,830	24.35	796	22.53	15,626	24.25
21 - 24 yrs. incl.	9,663	15.87	568	16.08	10,231	15.88
25 - 29 " "	6,743	11.07	431	12.20	7,174	11.13
30 - 39 " "	10,237	16.81	775	21.94	11,012	17.09
40 - 49 " "	10,273	16.87	507	14.35	10,780	16.73
50 - 59 " "	6,091	10.00	345	9.76	6,436	9.99
60 - 69 " "	2,582	4.24	79	2.24	2,661	4.13
70 yrs. and over	462	0.76	24	0.68	486	0.75
<u>Total</u>	<u>60,901</u>	<u>100.00</u>	<u>3,533</u>	<u>100.01</u>	<u>64,434</u>	<u>99.99</u>

The largest age group was the under 21-year category (16 - 20 yrs.)

with nearly one-quarter of all convicted persons in this group.

Over one-half, 51%, were under 30 years of age. The great majority

of convicted persons were male, 95%. Males and females have about

the same age distribution. Comparison with the Ontario population

estimates for 1971 shows that a relatively high proportion of persons

convicted were in the younger age group; there is a corresponding

deficiency for the older age groups. For those 20 years of age and

older the age group 20 - 24 years is 26% of convicted persons vs. 14%

for the total population whereas the 60 - 69 age group represents 5%

of convicted persons vs. 11% for the whole population.

### Length of stay and occupancy

The term for 70% of those sentenced to a definite prison term was under 30 days; thus, the term of imprisonment was frequently quite short and, in fact, the average days' stay for jails was only about 9.5 days.

It is of interest that the average days' stay seems to be somewhat less for the small jails - Toronto Jail 10.3 days vs. 3 small jails 6.6 days. The occupancy rate varies similarly with jail size. Overall occupancy is high - about 80% - and for the Toronto Jail it is about 95% vs. 43.3% for Group 1 (small) jails. The one jail, the Metropolitan Toronto (or Don) Jail has nearly one-third of the total jail load in terms either of persons committed or inmate days.

### Overcrowding

Overcrowding is as conspicuous as it is undesirable from the point of view of health. Obsolete facilities and overcrowding are particularly undesirable to the health of the individual and to the group in custody.

Illustrative data are given in Table 3:

TABLE 3

OVERCROWDING IN JAILS  
(Illustrative Data)\*

	Built (year)	Capacity	Inmate Population			% Occupancy average daily capacity
			Maximum (greatest)	Minimum (least)	Average daily population	
Toronto	1862	753	836	455	711	94.4
Hamilton	1875	142	163	84	118	83.1
Kenora	1928	57	148	29	98	171.9
Sudbury	1928	68	112	35	84	123.5
Brampton	1867	34	59	22	38	111.8
Peterborough	1866	24	46	19	31	129.2

\* Data are from Annual Report 1971, Pages 1, 50, 51.

Maximum numbers are for males and females;  
minimum numbers are for males; generally the  
least numbers of females were zero or 1 except  
for Toronto 16, and Kenora 11.

Transfers to other institutions

Of the 80,755 persons who were in custody in jails during  
the year ended 31st March 1971, 13,141 were transferred to other  
institutions and, of these, 10,839 were transferred to correctional  
centres and 144 transferred to training schools.

Thus, of the over 80,000 persons in custody, nearly one-half  
received definite prison terms but only a quarter of these are over  
30 days and this is the group, numbering about 10,000, which is  
moved from the jails to the correctional centres. Information con-  
cerning the jail population in individual jails is given in Appendix 12.



2. Health Services in Ontario jails (based mainly  
on responses to the Health Services Questionnaire)

(a) Hospital or infirmary

The jails generally do not have a sick bay or infirmary. Even the larger Toronto Jail does not have such a facility, although there is a psychiatric unit of 10 beds and 8 beds allocated for medical cases. These two units are actually sections of cell blocks designated for these purposes. Several of the small jails, Chatham, North Bay and Whitby, also designate certain cells for hospital or sick bay use. The new Quinte Regional Detention Centre does have a five-bed hospital unit consisting of one 2-bed room and 3 single bed rooms. This is evidently to be the pattern in the development of these regional detention centres which are to replace the jails.

(b) Health staff on full or part-time basis

Physicians

The jails usually make use of the part-time services of a physician practicing in the community as medical officer of the jail. Only the Toronto (Don) Jail has full-time medical doctor services with two physicians and one psychiatrist employed full-time in the jail. This jail also has a consultant psychiatrist and a consultant surgeon employed part-time on a sessional basis, and a part-time (relief) surgical consultant.

### Nurses

Only three jails have the services of one or more nurses who are employed by the Ministry on a full-time basis. Toronto Jail has eleven registered nurses and one other nurse; Hamilton Jail has one full-time nurse and Monteith Jail shares with the Correctional Centre and Adult Training Centre one full-time nurse. The Quinte Regional Detention Centre has recently employed one full-time registered nursing assistant. Windsor Jail has a part-time nurse. Only Toronto, however, has full-time nursing service in the sense of 24-hour coverage.

### Dentists

The jails generally make use of part-time dentists on a fee-for-service or other contractual arrangement, e. g. the Toronto (Don) Jail has a dentist providing emergency service one evening a week. Six dentists are employed full-time in correctional centres and training schools and three of these work in jails. One dentist serves a cluster of five institutions in the Brampton area - the jail and Adult Training Centre, the Mimico Correctional Centre, the A. G. Brown Memorial Clinic and the Vanier Centre for Women. Another dentist is employed full-time in the Guelph Correctional Centre, including the Neuro-Psychiatric Clinic and also serves the Guelph Jail. A third dentist has been engaged full-time serving the Cobourg Jail, Brookside School also at Cobourg, and Millbrook Correctional Centre.

Other health staff

The Toronto Jail also employs on a full-time basis a qualified (graduate) pharmacist, a qualified (registered) radiological technician, a medical clerk and a typist. In addition, two correctional officers are employed full-time on health services duties, including assisting with admission examinations, sick parades and distribution of medications. These correctional officers contribute to health services in a fashion similar to nursing orderlies in the Armed Forces.

Psychologists and Social Workers

There are six full-time social workers employed in jails - 3 at Toronto Jail and one each at Hamilton Jail, Ottawa-Carleton Regional Detention Centre and Quinte Regional Detention Centre. Three of these are "Classification Counsellors". In addition, Toronto Jail has a part-time social worker and one full-time psychologist.

(c) Laboratory and other diagnostic services

In Ontario jails the general procedure is for the height and weight of an inmate to be taken and skin inspection to be done and recorded in the course of admission to the jail by the correctional officer in the admitting department and again in the medical room in the course of an admission medical examination. Usually a urine specimen is tested using a simple stick test for sugar and albumin;

this is done in the medical room. These procedures were not consistently reported and the Committee has observed that urinalysis is by no means uniform throughout jails. Blood samples were not routinely taken; only about half a dozen jails reported blood tests, usually V.D.R.L. for syphilis. The Public Health laboratory generally does the analysis but hospital laboratories are used and one jail mentioned a commercial laboratory.

Some other diagnostic procedures were carried out on occasion or as indicated, such as examination for gonorrhoea per vagina. The indications for examination for venereal disease, judged by the incidence of examination, varied from jail to jail. For a few other jails blood cell counts and ECG's were done at the local general hospital. Large TB chest films were taken, and read by the Public Health Department or hospital for several jails. One jail mentioned "pap" smears and another vision and hearing tests. In both cases the local hospital was involved.

With the exception of the urine test there is essentially no regular use of screening tests in jails. In general, the pattern of examination on admission to jails is inconsistent and shows little uniformity. However, the jails usually are able to call on local health services, particularly the general hospital, for emergency or other requirements and regularly receive cooperation.

(d) In-patient (bed) care

In the absence of a sick bay or infirmary facilities the jails

were not in a position to report on in-patient care in terms of accommodation, admissions or bed-days of care.

(e) Mortality

There were 10 deaths, one in each of 8 jails and 2 in Toronto Jail reported from 40 jails during the year ended 31st March, 1972. Five of these were deaths from disease, two from accidental injury and one unspecified. These 8 deaths all occurred in hospital after transfer from the jail. There were two suicides, one each in the London Jail and Quinte Regional Detention Centre. (Two additional suicides in one jail came to the attention of the Committee in the course of visits to institutions between March and August, 1972.)

(f) Health care records

The Medical Status Summary Form 9801 is used in all jails and is generally initiated on admission of the inmate. Two of the jails, however, reported that it was initiated on medical examination or the occurrence of illness.

The general physician-medical officer is most commonly the only person to make entries but the psychiatrist, nurses (particularly the head nurse) and the dentist may also make entries on this form. The correctional officer may record height and weight along with name and age on admission. The superintendent is occasionally reported as using Form 9801.



Generally the forms are filed in the records room of the institution with the inmates' general file, but some of the medical records are kept in the control office, jail office or admitting office (these may be different names for the same place). All jails replied negatively to the question about inmates handling or filing medical records. Most commonly they are filed alphabetically; in about one-third of the jails records are filed serially by inmate number. These records are usually kept in the institution when the person leaves but when the original goes with the person on transfer a copy is generally retained; the procedure is by no means uniform. Some jails retain the copy only if the original goes with the inmate to a penitentiary.

The Accident and Injury Form 9890 is usually seen by the medical officer and completed only after examination of the person injured. Most jails reported that the information on this form is also included on Form 9801. Accident and injury reports were made during March 1972 by 15 out of 40 jails. The distribution of the 33 cases was as follows:

<u>Reports</u>	<u>Jails</u>	<u>Cases</u>
0	25	0
1	8	8
2	3	6
3	1	3
4	1	4
12	1	12
unspecified	<u>1</u> <u>15</u>	<u>          </u>
	<u>40</u>	<u>33</u>

There is no consistent or uniform procedure in the jails for handling the Transfer to Hospital Form 9811. The medical officer or nurse does not generally initiate the form which is, rather, initiated by the superintendent, the correctional officer in charge of the shift, or the clerk (24/40 jails). The medical officer or nurse, however, commonly provides information for the form (24/40 jails). A similar proportion of the jails reported that the medical information is also recorded on Form 9801, otherwise it is entered on a daily log, jail register or the doctor's order book. Transfers to hospitals (68) were reported by 14 of 40 jails for March, 1972. Statistics of transfers during January to March, 1972, or some recent three-month period were provided by 12 of these hospitals and these transfers were classified as follows:

<u>Purpose</u>	<u>Toronto</u>	<u>Others</u>	<u>Total</u>	<u>%</u> <u>(by purpose)</u>
a) Diagnosis	92	10	102	57.0
b) Treatment	46	22	68	38.0
c) Operation	<u>4</u>	<u>5</u>	<u>9</u>	<u>5.0</u>
	<u>142</u>	<u>37</u>	<u>179</u>	<u>100.0</u>
% (by jail)	79.3%	20.7%	100.0%	

It is of interest that the Toronto Jail, which has about one-third of the inmate days and persons committed to jail, accounted for nearly 80% of the transfers to hospital reported for this period and about 56% (38/68) for the month of March, 1972.\*

\*The Committee has been advised that institutions in the north transfer men to either the Toronto Jail or Mimico Correctional Centre to utilize the wider range of in-patient and out-patient medical services provided by the large hospitals of the Toronto area, and to reduce the waiting period for hospital beds for elective surgery. This contributes to the disproportion of hospital referrals from the Toronto Jail. (See Page 57)

Other records

There is variability or a lack of uniformity in the use of other records or in the reporting of them. Fifteen jails reported using dental charts; 9 reported some form of medical examination report and 9 jails mentioned a drug report form. In addition, one jail referred to a TB record and another one to an X-ray record form. Twenty-four jails reported using Form 597 and another 9 jails used some other form of medical diary, mostly a doctor's log or case book. Some figures were given for the numbers of forms used and these evidently referred mainly to admission examination.

(g) Physical facilities

The physical facilities for health care in jails are generally quite inadequate.

A bare majority of the jails (23/40) did report that a separate room was available for the medical officer to see and treat patients and about half considered the space adequate. However, of the 15 jails that gave dimensions, 7 were very small - 81 sq. ft. or less; one of 100 sq. ft. is in about the same category, and only 7 could be considered adequate having 110 to 480 sq. ft. Generally, there is no other room available for physician use or for sick parade. About half the jails have an examining table for the doctor, even if improvised, some others use a cell bed and a few have an examination room.

There are essentially no treatment facilities for nurses to use but the Quinte Regional Detention Centre fortunately has provided a room for a nurse. The dentist usually does not have an office or a chair. He may use the doctor's room. At Quinte Regional Detention Centre a room is provided for the dentist with a dental chair in the sick bay area. The Toronto Jail nurses have a room for treating inmates and there is also a dental chair available. Chatham Jail was the only other jail that indicated that a dental chair was available.

Suitable physical facilities are essential for good medical and dental care but the situation is understandable, if unacceptable, in view of the age of the buildings.

(h) Custody of drugs

The situation concerning the custody of drugs is disturbing. In only four jails is there a room available for use as a drug dispensary. Drugs are variously kept in the control room, superintendent's office, or medical officer's office, in drug cabinets, locked cupboards or cabinets, a store room or, in a few instances, in a safe or vault. There is no consistency or uniformity in the practices respecting drug custody.

(i) First Aid

Nearly all jails reported that the correctional officers were trained in first aid and many had first aid kits available. A number had a Brooks Airway or other resuscitator equipment; several had

a stretcher on hand. Again, there is no uniformity in the practice.

(j) Sick parade

A regular sick parade is held in about half the jails (21/40) but with various frequencies, a daily parade being most common. A sick parade is held in some jails at less frequent intervals; i.e. once, twice or three times a week. In addition, there are pill parades held in about 20 jails, usually three times a day. The regular sick parade is generally held in the medical officer's office but occasionally the jail office or other space is used. There is usually (27/40) no waiting room for inmates waiting to see the medical officer. However, it is reported that interviews and examinations are conducted in private in nearly all jails. It is also reported that in all jails the inmate is able to see the medical officer at sick parade or on request. Requests are screened in 10 jails - 6 of these by the correctional officer and the other four by the nurse. In 8 of these 10 jails, the medical officer is advised at least of the health problem or complaint of those screened. At the Toronto Jail the medical officer sees about 70% and the nurse 30% of those screened and at Monteith, about two-thirds are seen by the medical officer and one-third by the nurse. In most jails (36/40) entries are made on Form 9801 for all sick parade attendances.

Attendance at sick parade averages from one to 35, but most cases is less than 10. In relation to the average daily census it appears that about 17% appear at sick parades but this proportion



varies greatly. As expected, the proportion attending is higher where the sick parades are held less frequently than daily and at one jail, for instance, it appears that virtually all present usually attended the weekly sick parade. Some relevant data are given on the following page. (Table 4)

### 3. Observations on general and specific health problems in jails

#### General observations on health services in jails

The medical officer is responsible to the superintendent for his professional activities and the proper discharge of his duties. The medical officer is sometimes unaided or may be aided only by a correctional officer (save in Toronto, Hamilton, Windsor, Quinte and Monteith) who rotates frequently and who is euphemistically entitled a "hospital officer" when working in the sick bay or infirmary. His only special Ministry training is a St. John Ambulance first aid course taken as part of his training as a correctional officer. He issues controlled and non-controlled drugs to inmates in almost all jails and detention centres at night, save the Toronto (Don) Jail, and in the great majority of jails in the daytime also. He may or may not weigh the inmate appearing at sick parade or for admission medical examination, count his pulse or examine the urine for sugar and albumin.

TABLE 4

ILLUSTRATIVE DATA ON ATTENDANCE AT REGULAR SICK PARADES IN JAILS  
(may not include parades conducted by nurse or correctional officer)

FOR THE YEAR ENDING MARCH 31, 1972

Group	Jail	Sick parade frequency	Average daily census	Sick Parade Attendance				Average* attendance as % of average daily census
				Total during year	Number during March 1972	Average daily number	Average per parade	
6	Toronto	1/d	607	8,715	735	35	35	5.77
5	Hamilton	1/d	107	7,200	620	20(min.)	20(min.)	18.69
4	Kenora	5/wk	93.2	3,634	215	10	14	15.02
	London	3/wk	80.62	3,000	250	20	19	23.57
	Ottawa	5/wk**	85.2	5,200	490	21	27	31.69
	Quinte RDC (open 8/6/71)	1/d	69	2,129	233	9	10	14.49
	Windsor	1/d	79	1,786	142	10	8	10.13
3	Barrie	1/d	34	1,482	110	5	5	14.71
	St.Catharines	1/d	36.6	1,918	148	7.4	7.4	20.22
	Sarnia	2/wk	33.05	1,203	64	11.5	7	20.90
2	Brampton	1/d	38.75	1,630	89	8	8	20.65
	Brantford	1/wk	24.8	1,481	133	N/A	26	104.84
	Fort Frances	2/wk	8.67	266	24	1.37	5	57.67
	Guelph	2/wk	21	700	60	-	7	33.33
	Haileybury	1/wk (on request)	25.41	900	24	N/A	17.30	68.08
	Lindsay	1/wk	12	384	34	6.5 per visit	6.8	56.67
	North Bay	2/wk	27.57	600	80	5	12	43.53
	Peterborough	3/wk	22.17	1,047	99	7.76	9	40.60

\* Average attendance per parade.

\*\* Daily, Monday to Friday.

Source: Replies to Health Services Information Questionnaire, May, 1972 (Appendix 8).

Where nurses are employed in the jail they may or may not report to the medical officer regarding the cases they have treated for the physician's approval. They may or may not record their professional activities on Form 9801.

Radiation protection (x-ray machines in jails)

X-rays are taken by various correctional officers. Pre-cautions to protect the operator have rarely been reported or observed by the Committee. Film badges to be worn by the operator, judged by our visits and enquiries, are not used in jails; the system of supervision and maintenance of x-ray equipment to protect against diffusion of ionizing radiation potentially damaging to the operator seemed inadequate in all jails visited.

Venereal Disease

Syphilis - Serological examination of the blood (Wasserman or V.D.R.L.) is not a regular part of the admission examination to jails in Ontario.

Gonorrhoea - In males, urethral smears and cultures or pre-voiding morning inspection for urethral discharge are not carried out unless the inmate or his fellows complain. In females, no Ministry policy seems to exist regarding indications for vaginal search for contraband\* on admission to jails or for the taking of cervical smears and cultures in

\*The Committee has been advised that the practice is that such a search is conducted if the woman is a known drug addict; if information is given to the jail authorities that contraband is so concealed or if reasonable grounds of suspicion otherwise indicate the necessity of a search.

search of relatively asymptomatic gonorrhoea. The difficulties are acknowledged to be conspicuous because of the wide range of reasons for admission to jails, ranging as they do from unpaid parking tickets to non-capital murder.

#### Quality of medical services in jails

The quality of medical care varies remarkably from jail to jail; it is influenced by the number of admissions and discharges, by the number of inmate days in relation to the time of the physician contracted for by the Ministry, by the contribution of the nursing service, by the size of the sick parades, by the general morale of the institution and conduct of inmates at sick parade, and by the professional qualifications and insights and responsible initiative of the individual physician.

Observation makes it clear that the fact that Form 9801 has been filled out with such phrases as "negative for disease", "nil", "fit for duty" or "no complaints", is no assurance that new admissions to jails or repeaters have been examined effectively. In some instances, admissions to jails are not examined at all or only a token examination prior to transfer is done. This may be because of lack of time, especially if inmates are repeaters who are known to the physician.

This observation is of major importance both in jails and to the medical staff of adult correctional centres receiving transfers from jails.

#### 4. Diseases, symptoms and services recorded in jails

##### Diseases and symptoms recorded in jails

Studies of the information recorded in the Medical Status Summary Form 9801 and its supplement 9802 were carried out at four jails: at Toronto and Brampton by a team under the direction of Dr. le Riche of the University of Toronto, and at Quinte Regional Detention Centre and Ottawa Jail by a team directed by Drs. Steele and Kraus of Queen's University (Appendix 9). These studies were to obtain illustrative data concerning the illnesses, complaints or health problems for which inmates sought health care and the services provided or initiated by the health services staff, mostly physicians, but occasionally by psychiatrists, nurses, dentists and sometimes correctional officers, insofar as these were recorded on Forms 9801-02. The sample was small in terms of jails and inmates but the records covered the whole period of the inmates' stay in the jail or R.D.C.

The most common diseases and symptoms are shown in Table 5 (with more detail in Appendix 9). It is evident that alcoholism and drug dependence are the major component of the mental disorders class and together account for 16% of the total cases. The next most important single category was the common cold with nearly 8% cases. The next most prevalent symptoms or complaints, coded as "disturbance of sleep" and "nervousness or debility", each amounted to 5% of the total. While the former two conditions were



TABLE 5

MOST COMMON DISEASES AND SYMPTOMS RECORDED IN JAILS

Recorded on Form 9801-02 at admission examinations and other contacts

(Records may not include entries for screening or treatment  
by nurses or correctional officers)

CASES\* - TOTAL FOR FOUR JAILS\*

(Toronto, Brampton, Quinte R.D.C. and Ottawa)

ICDA Nos.	Disease, Injury or Symptom	Admission exams	Other contacts	Total cases	
				No.	%
303	Alcoholism	62	1	63	9.78
304	Drug dependence	41	1	42	6.52
345	Epilepsy	14	3	17	2.64
460	Acute nasopharyngitis (common cold)	23	27	50	7.76
490-2	Bronchitis and emphysema	16	2	18	2.80
520-5	Diseases of teeth and gums, etc.	3	10	13	2.02
780-6	Disturbance of sleep	11	23	34	5.28
788-2	Rash, skin eruptions, NES	9	9	18	2.80
790	Nervousness and debility, NES	23	11	34	5.28
791	Headache, pain in head, NES	6	8	14	2.17
870-907	Laceration and open wound	14	4	18	2.80
920-929	Contusion and crushing with intact skin surface	15	1	16	2.48
	Total specified	237	100	337	52.33
	Others	198	109	307	47.67
	Total Cases*	435	209	644	100.00

\* 1) No. of inmates: Toronto 400, Brampton 100, Quinte 100, Ottawa 100 - Total 700

No. of cases: Toronto 403, Brampton 20, Quinte 124, Ottawa 97 - Total 644

2) Case= Inmate with a particular disease, injury or symptom;  
Inmate counted only once for each such "diagnosis" recorded.

3) Most common= Disease, injury or symptom accounting for 2% or more of  
total cases. NES = Not Elsewhere Specified.

4) ICDA Nos. = Eighth Revision International Classification of Diseases  
adapted for use in the United States. U.S. PHS publication  
No. 1693 Vol. 1(1967); Vol. 2(1969).

Source: Medical Record Field Studies (Appendix 9)

nearly all found at admission examination the latter three, as might be expected, were recorded at both admission examination and other contacts. Other than ulcers the digestive conditions are mainly symptomatic and again the skin conditions are expressed as symptoms. The prevalence of epilepsy and of injuries is noteworthy. There is a substantial number and proportion of conditions that are vague or ill-defined disorders or complaints including nervousness and debility which results in the medical officer's order to leave the "cell door open".

These records were examined at only four jails - Toronto, Ottawa, Brampton and Quinte Regional Detention Centre - and the Toronto data dominate the findings. However, there seemed to be some consistency among these jails save for Brampton.

The predominance of symptomatic conditions rather than disease diagnoses is noteworthy and reflects the expression by inmates of vague complaints to get attention, have a change of scene, or to get off work, or, on the other hand, inadequate examination due to lack of time, interest, or proper psychiatric understanding on the part of the medical officer.

#### Health services recorded in jails

Notwithstanding the prevalence of the inmates' search for pills and the treatment of symptoms rather than of recorded diagnoses, there is little evidence of abuse (judging by the medical records, Forms 9801 and 9802) by an over-use of the physicians' services by the majority of prisoners. Even this observation is

clouded because screening and treatment of prisoners' minor complaints was done by correctional officers and by nurses and often without making entries on Form 9801 and 9802. The frequency of contacts of inmates with medical officers or others providing health services as recorded on Forms 9801 - 02 is shown in Table 6.

A significant fact here is that over three-quarters (77%) of the inmates had no recorded contact with the physician other than the initial (mandatory) medical examination; this finding may be recognition of both the competency of the nurse and of inadequate health records. The overall ratio of recorded contacts per inmate is 0.41, i. e. about a contact for each two inmates. For those with contacts, the ratio is still less than two per inmate for the total jail stay. A few inmates record many contacts, the largest number being 10.

Those inmates whose records were examined had stays averaging 10 days except for Brampton where the average stay was about three weeks.

Aside from admission physical examinations and blood tests and urinalyses, which may have been included in the admission examinations, the most common service is the administering of pills or other medications (16%). The types of service performed or provided for inmates in jails is indicated in Table 7. The prescribing of special diets, and referrals, especially to dentists, were next in frequency. A variety of other services were occasionally provided including psychiatric examination, the dressing of wounds, the application of splints or casts, or the providing of equipment such as a fracture board.

TABLE 6

DISTRIBUTION OF INMATES BY NUMBER OF MEDICAL CONTACTS IN JAILS  
(excluding admission examinations)

AS RECORDED ON MEDICAL RECORD FORMS 9801-9802

(Records may not include entries for screening or treatment  
by nurses or correctional officers)

	Number of contacts	Toronto	Brampton	Quinte R.D.C.	Ottawa	Total Inmates		Total contacts
						No.	%	
	0	331	72	66	67	536	76.57	0
	1	40	20	22	21	103	14.71	103
	2	16	2	8	3	29	4.14	58
	3	9	5	4	4	22	3.14	66
	4	1	1	-	2	4	0.57	16
	5	1	-	-	-	1	0.14	5
	6	1	-	-	2	3	0.43	18
	7	-	-	-	-	-	-	-
	8	-	-	-	-	-	-	-
	9	-	-	-	1	1	0.14	9
	10	1	-	-	-	1	0.14	10
Total inmates		400	100	100	100	700	99.98	
Total contacts		124	43	50	68			285
% of inmates with no contacts		82.75	72.00	66.00	67.00		76.57	
Average contacts per inmate		0.31	0.43	0.50	0.68			0.41
Total inmates with contacts		69	28	34	33	164		
Average contacts per inmates with contacts		1.80	1.54	1.47	2.06			1.74

Source: Medical Records Field Studies (Appendix 9)

TABLE 7

HEALTH SERVICES RECORDED IN JAILS  
(including admission examinations)

INMATES WITH SPECIFIED SERVICE - BY JAIL (RDC)

AS RECORDED ON MEDICAL RECORD FORMS 9801-9802

(Records may not include entries for screening or treatment by nurses or C.O.'s)

No.	Service	Toronto	Brampton	Quinte R.D.C.	Ottawa	Total	
						No.	%
01	Routine physical examination on admission	400	100	85	94	679	41.38
02	Follow-up examination or recheck	3	-	-	-	3	0.18
04	Partial or incomplete physical examination	1	-	-	-	1	0.06
06	Psychiatric examination	16	-	-	-	16	0.98
09	Other examinations and tests	-	-	1	-	1	0.06
11	Operation or surgical procedure	-	-	1	1	2	0.12
14	Diagnostic radiography	-	100	3	1	104	6.34
15	Physical medicine and rehabilitation	-	-	1	-	1	0.06
17	Dressing of wounds	6	-	-	-	6	0.37
18	Application of equipment (tensors, splints and casts)	2	-	-	-	2	0.12
25	Analysis or test performed	-	-	1	-	1	0.06
26	Analysis or test interpreted	405	100	-	-	505	30.77
.1	Blood test	(5)				(5)	(0.30)
.7	Urinalysis	(400)	(100)			(500)	(30.47)
27	Equipment dispensed (e.g. fracture board)	-	-	2	-	2	0.12
31	Consultation and advice; counselling and teaching	4	-	-	-	4	0.24
41	Referred to - Psychiatrist	-	-	-	3	3	0.18
42	Referred to - Other medical specialist	-	-	4	-	4	0.24
44	Referred to Dentist	7	1	6	1	15	0.91
48	Referred to - Outside hospital	-	-	-	1	1	0.06
49	Referred to - Optometrist	-	1	-	-	1	0.06
51	Medication (pills and other) administered	144	26	60	30	260	15.84
61	Diet - special prescribed	4	13	2	5	24	1.46
71	Admitted to Institution hospital	5	-	1	-	6	0.37
TOTAL INMATES		997	341	167	136	1,641	99.98

Source: Medical Records Field Studies (Appendix 9)



#### IV. ADULT CORRECTIONAL INSTITUTIONS (EXCLUDING JAILS)

##### 1. Basic data about correctional institutions and their inmates

Persons (adult males and adult females) are transferred from jails to correctional and training centres and are assigned to an initial institution by the Chief Bailiff with the approval of the Deputy Minister. In cases involving sexual deviancy, misuse of drugs, or arson, and severe custodial or behavioural problems, the transfer may be to the Millbrook Correctional Centre or a clinic. Transfers may be made from jails directly to the Alex G. Brown Clinics for treatment of drug addiction or sexual deviation. The Liquor Control Act provides for such direct transfer in certain liquor offenses to "a centre for the reclamation of alcoholics". No formally defined treatment program exists for the homosexual or exhibitionist. The clinics have a pedophile program. The other two major classes of sexual deviation are not provided for in a treatment sense.

The Director of Medical Services would become involved in these transfers only if a special medical problem were to arise. The practice of having the Director of Psychology review such transfers has been discontinued. In any event, these are essentially decisions made on the basis of reading incomplete reports. They are not based upon any direct examination of the sexually deviated or drug abusing offender.

Arson cases, on the other hand, are referred directly to the Guelph Neuro-Psychiatric Clinic for appraisal and classification.

### Adult Females

All females in Ontario sentenced to terms ranging from 30 days to 2 years are sent to the Vanier Centre for Women, Brampton. The medical records study team found an average stay of 3.45 months for 100 inmates discharged during the period September 1, 1971, to March 31, 1972. This centre is a medium security institution with accommodation for 120 inmates and there is associated with it a unit with maximum security accommodation for 12 persons in the Toronto Jail.

The Toronto Jail unit is used for those with limited personal controls until such time as they are considered capable of functioning in a less secure and more challenging setting. Physical assault, including hair pulling, on another inmate or a correctional officer, is automatically followed by transfer to the Toronto Jail. On the occasions of the visits of the Committee and the consultants to the Toronto Jail, the Vanier group appeared to be confined under circumstances indistinguishable from other female inmates.

### Adult Males

Adult male prisoners will be transferred from jail to one of a variety of correctional institutions. Persons undergoing first imprisonment and all who are from 16-18 years of age from Central and Southern Ontario will be sent to the Guelph Correctional Centre for initial assessment.

The prisoner may be continued in Guelph Correctional Centre which is a medium security institution with accommodation for 777. This is the main classification centre for the young offender.

Prisoners at Guelph who are in the age group 16-24 years and are considered to be good custodial risks and are well motivated are assigned to the adult training centres - Burtch (accommodation for 60) and Brampton (accommodation for 144).

The young prisoners, age 16-24 years, who are good custodial risks and well motivated and are from the Northeast, North and Northwest of the province, are assigned to the Rideau, Monteith and Thunder Bay Adult Training Centres respectively. These are all minimum security institutions with accommodation for 60 persons each.

Recidivists are sent to other correctional centres - Burwash (accommodation for 590), Thunder Bay (accommodation 68), Monteith (accommodation 120), Rideau (accommodation 160) and Burtch (accommodation 200). Allocation is on a geographic basis.

Millbrook Correctional Centre is the only maximum security institution for adult males. The Centre, with accommodation for 234, receives drug addicts who are security risks, sex deviates, arsonists and other prisoners who present custodial or severe behavioural problems.

Forestry camps are associated with some of the adult male institutions and are administered by the same superintendents. At

the end of the year, March 31, 1972, there were seven camps each with a capacity of about 40. Two of these camps are now being used for juveniles.

Inmates are also screened for transfer to the Alex G. Brown Memorial Clinic located at Mimico. This 104-bed clinic has facilities for the treatment of drug addiction, alcoholism and sexual disorders. Group and individual programs are attuned to the individual patient's needs. These programs may include aversive conditioning, chemotherapy, psychotherapy, industrial therapy, educational films, group discussions, arts and crafts and lectures. The short-term program for alcoholics has been expanded to include other forms of chemical abuse and the thirty days' treatment period has been extended to a 40-70 day period. The long-term program (3-6 months) for drug abusers now includes alcoholics. A new clinic facility with accommodation for 200 patients is being constructed on a site adjacent to the Brampton Adult Training Centre.

Psychiatric diagnosis and treatment are provided at the Guelph Neuro-Psychiatric Clinic for inmates referred there by an institution physician. In the absence of the physician, referral of an apparently acutely disturbed patient to the N. P. C. may be made by the superintendent of the referring institution following telephone discussion of the case with the Director of the N. P. C. After assessment the inmate may be accepted as an in-patient; may be given out-patient care while staying at the associated Guelph Correctional

Centre; may be committed for admission to an Ontario Psychiatric facility; or may be returned to the referring medical officer with recommendations for treatment. The Neuro-Psychiatric Clinic has a capacity for 24 patients.

Sex and age

The sex and age distributions of persons committed to adult institutions, other than jails, are shown in Table 8:

TABLE 8 .

SEX AND AGE DISTRIBUTION OF PERSONS COMMITTED TO  
ADULT INSTITUTIONS DURING THE YEAR ENDING MARCH 31, 1971  
(excluding jails)

<u>Age Group</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>	<u>No.</u>	<u>%</u>
Under 20 years	2,239	23.94	92	25.27	2,331	23.99
20 - 24 years inclusive	2,195	23.46	110	30.22	2,305	23.72
25 - 29   "       "	1,028	10.99	50	13.74	1,078	11.09
30 - 34   "       "	634	6.78	40	10.99	674	6.94
35 - 39   "       "	703	7.52	36	9.89	739	7.60
40 - 44   "       "	685	7.32	17	4.67	702	7.22
45 - 49   "       "	649	6.94	7	1.92	656	6.75
50 - 54   "       "	498	5.32	5	1.37	503	5.18
55 - 59   "       "	315	3.37	4	1.10	319	3.28
60 - 64   "       "	249	2.66	2	0.55	251	2.58
65 - 69   "       "	103	1.10	-	-	103	1.06
70 years and over	56	0.60	1	0.27	57	0.59
<u>Total</u>	<u>9,354</u>	<u>100.00%</u>	<u>364</u>	<u>99.99%</u>	<u>9,718</u>	<u>100.00%</u>
<u>By Sex</u>		<u>96.25%</u>		<u>3.75%</u>		<u>100.00%</u>



The largest age group was the under 21 years category (16-20 years) with 24% of all persons committed to adult institutions in this group, a figure closely paralleling the distribution of persons convicted (Table 2, Page 23). A relatively high proportion of those committed are in the younger age group, especially the 20-24 years of age group, in comparison with the Ontario population generally.

### Recidivism

The extent of recidivism for persons committed to adult institutions is indicated in Table 9 which shows that 51% of these persons had previous institutional sentences. Less than 10% had had penitentiary sentences. No data are available concerning previous residence in a training school.

TABLE 9

### PREVIOUS INSTITUTIONAL HISTORY

PERSONS COMMITTED DURING YEAR ENDING MARCH 31, 1971

#### Adult Training and Correctional Centres

<u>Previous institutional sentences</u>	<u>No.</u>	<u>%</u>
None	4,648	49
One	1,270	13
Two	745	8
Three	442	5
Four or more	<u>2,444</u>	<u>25</u>
<u>T o t a l</u>	<u>9,549</u>	<u>100%</u>

### Inmate population

The statistics of inmate volume and movement which were summarized for all institutions and schools in Table 1 are shown for each adult institution (excluding jails) in Table 10. Only Burwash, Guelph and Mimico Correctional Centres have populations of over 200 at any one time. Burtch and Millbrook Correction Centres and Brampton Adult Training Centre each have between 100 and 200 inmates; the other centres have populations of less than 100. The Annual Report (1971) statistics show that there is a considerable movement by way of transfer among those institutions and between them and the jails; this amounts to nearly 15% of the total in custody during the year. There is a turnover ratio (committed/average population) of 3.6 reflecting in part average stays of 2 to 3 months. Occupancy (population/capacity) is about 72% for all these institutions but varies substantially from just over 50% for Thunder Bay Correctional Centre to 86% for Vanier Centre for Women.

## 2. Health Services at Correctional Centres\* (based on responses to the Health Services Questionnaire)

### Physical facilities

The physical facilities for health services at the correctional centres with few exceptions are inadequate and, certainly, generally should be improved. Of the nine correctional centres, including Vanier, four seem to provide an office for the medical officer

\*Most adult training centres are attached to correctional centres and share the same health services staff and facilities. This discussion will, therefore, be in terms of correctional centres.

TABLE 10

INMATE POPULATION AND MOVEMENT

ADULT INSTITUTIONS (EXCLUDING JAILS)

Institution	Movement during year ended March 31, 1971			April 2, 1972	
	Committed	Total in custody	In custody end of year	Population count	Capacity
<u>Correctional Centre - Women</u>					
Vanier	317	403	89	98	120
Toronto Jail Unit	47	48	9	14	10
Total - Female	364	451	98	112	130
<u>Correctional Centre - Men</u>					
Burtech	970	1,154	165	132	200
Burwash (1)	778	1,348	544	431	630
Guelph (1)(2)	1,918	2,703	743	682	881
Millbrook	387	575	195	174	234
Mimico (1)(3)	2,081	2,478	362	310	503
Monteith	525	622	82	98	120
Rideau	775	878	78	83	160
Thunder Bay	365	422	47	61	68
Total	7,799	10,180	2,216	1,971	2,796
<u>Adult Training Centre</u>					
Brampton	262	387	133	135	144
Burtech	111	164	38	43	60
Monteith	162	212	43	45	60
Rideau	171	211	62	55	60
Thunder Bay	115	161	39	39	60
Total	821	1,135	315	317	384
<u>Forestry Camp</u>					
Durham	167	177	10	7	15
McCreights	567	609	43	13	48
Total	734	786	53	20	63
Total - Male	9,354	12,101	2,584	2,308	3,243
TOTAL MALE AND FEMALE	9,718	12,552	2,682	2,420	3,373
(1) Including Forestry Camps - population count midnight 2/4/72, all camps (excluding Durham and McCreights) - Burwash: Wendigo 1, 40; Guelph: Dufferin 32, 40; Oliver 34, 40; Mimico: Hendrie 14, 40; Hillsdale 20, 29				101	189
(2) Including Guelph N.P.C. - population count midnight 2/4/72				7	24
(3) Including A.G. Brown - population count midnight 2/4/72				71	104

Sources: Annual Report 1971; Population Counts (See Table 1)

adequate in size. Only one has the office for the medical officer separate from other medical rooms; three of the centres have full-time physicians and all three of these have a suitable office.

Generally, though, one room only serves all medical purposes with the physician, psychiatrist, nurses and sometimes also the dentist sharing facilities.

Seven of the nine centres have a hospital or sick bay and these range in size from 4 to 31 beds. These beds may be just regular beds in cells used for hospital purposes. Four centres reported patients admitted for bed care, the numbers ranging from 200 to 850 for the year ended March 31, 1972. In general, none of the beds are designated for particular diagnostic categories. Some recognition is given to the need for isolation, which it would be extremely difficult to make effective.

The Committee has been advised that: "The category of 'medical segregation' is used and designated cell wings are used for this purpose at Burwash and Guelph Correctional Centres in cases of communicable disease. Mimico Correctional Centre tends to utilize the Toronto Jail for medical isolation. When relatively large numbers of cases of a particular disease are diagnosed, e.g. infectious hepatitis or influenza, all infected inmates may be assigned to a segregated wing or dormitory of the institution."

Each of the centres has an examining table located in the doctor's office or in the examining room judging from the Questionnaires and from institutional visits. Interviews and examinations

by physician and nurse are not conducted in private in all the correctional centres.

#### Dentistry

Only five of the nine centres has a room for the dentist and none provides for the services of a dental hygienist. All but one centre has a dental chair which is sometimes located in the medical room.

#### Nurses

The nurses are inadequately provided with office space and relevant facilities. All centres but one have at least one full-time nurse, the numbers range from 1 to 5, but only two have a separate room available from which to provide professional services.

#### Emergency equipment

Some emergency equipment is kept in all centres, usually a resuscitator apparatus and first-aid kits. The facilities are rudimentary and not uniform. Among the items reported are Brooks Airways apparatus, inflatable splints, pocket or face masks, oxygen ventilators and portable oxygen tanks, stretchers, wheelchair and shock therapy tray.

#### Drug Dispensary

A separate room is, however, available for use as a drug dispensary in six of the nine centres. In the other three, the nurse's office or medical room is used.



### Health records

Medical records are kept in the physician's office most commonly, but may also be kept in another medical room or in the dispensary. Here, as in drug custody, there is a lack of uniformity in practice.

The Medical Status Summary Form 9801 is used in all correctional centres. It is initiated in the jail before the inmate reaches the centre or is initiated at the time of the first examination at the centre. While the medical officer makes most of the entries on 9801, the psychiatrist, head nurse and other nurses also use the form. In two of the centres it was mentioned that the superintendent in one and a correctional officer in the other may make entries on behalf of or advice of the medical officer. These forms are filed in the medical officer's office or the medical room and are filed alphabetically. One centre keeps two sets and files one alphabetically and the other serially. In two centres inmates DO handle the medical records.

Generally (7/9) the original Forms 9801-02 are retained in the centre when the prisoner leaves, but two centres retain a copy rather than the original. On transfer of an inmate from the centre the documents are sent with him but a copy is retained in the centre, with one exception.

The Accident and Injury Report Forms 9890 are seen by the medical officer at the correctional centres and he completes the

physician's section only after examination of the person injured. The information is also generally (7/9) recorded on the Medical Summary Form 9801. While several centres kept no record of the reports, five centres gave numbers of reports for March 1972; these are shown below with population count (April 2, 1972) for comparison:

Accident and Injury Reports - Form 9890

	<u>Reports</u>	<u>Population</u>
Burwash	21	431
Guelph	6	682
Mimico	22	310
Millbrook	22	174
Thunder Bay	9	100

The procedure for dealing with the Transfer to Hospital Form 9811 is not uniform but in all but one centre the medical officer and/or nurse provide information for the form. The information is usually also recorded on 9801 or some other form.

The numbers of transfers to hospital on the medical officer's recommendation reported for March 1972 were:

- 0 for one centre (Thunder Bay)
- 1 for each of three centres  
(Vanier, Burwash and Millbrook)
- 4 for one centre (Mimico)\*
- 11 for one centre (Burtch)
- 33 for one centre (Guelph)

Two centres did not report transfers. Only three centres reported numbers of transfers to outside hospitals by type of service. These were as follows:

\*This does not support the opinion that men are more frequently transferred to hospital from Mimico because of inmates transferred to Toronto for medical treatment. (See Page 32)

	<u>Vanier</u>	<u>Guelph</u>	<u>Millbrook</u>
Population count, April 2, 1972	<u>98</u>	<u>682</u>	<u>174</u>
<u>Transferred to hospital</u>			
January-March, 1972:			
(a) Diagnostic	2	42	0
(b) Treatment	3	19	0
(c) Operation	<u>3</u>	<u>30</u>	<u>1</u>
	<u>8</u>	<u>91</u>	<u>1</u>

Making allowance for the relative size of the population of these three institutions, the variability is striking and noteworthy and Millbrook is conspicuous.

Other health records

Several centres, such as Vanier and Guelph, have their own set of medical records as well as using Form 9801 and nearly all centres use a drug report form and a dental chart.

The procedures with respect to laboratory and other diagnostic services is not uniform for the correctional centres. All record height and weight and, in most centres, blood and urine samples are taken as part of the initial examination. For two of the centres this information was not provided to the Committee. Large film x-ray examination for tuberculosis detection is also quite common. Vision tests, using the Snellen chart, are done in most centres. Hearing tests are rarely recorded. All centres seem to make use of community resources including Public Health laboratories and the health unit and particularly the local general hospital for diagnostic work including ECG's and EEG's as required. Again, incon-

sistency or lack of uniformity in these practices is evident; even VD tests are not uniformly done and results obtained.

### Sick parades

Sick parades are held by physicians in all centres except one. Some information concerning sick parade attendances are given in the table on the following page (Table 11).

Sick parades are generally held in the medical officer's office or medical room but usually there is no waiting room available. The lack of privacy is sufficiently serious that in at least one-third of the centres interviews and examinations are not conducted in private. There is a screening of requests to see the medical officer in six of the nine centres. In five centres the screening is done by the nurse and in the other one by the correctional officer. The medical officer is generally, but not in all correctional centres, advised of the name and health complaint of those screened. In most centres the numbers seeing the medical officer or nurse is not recorded or reported. Entries are usually made on the Medical Summary Form 9801 for sick parade attendances.

### 3. General observations on sick parades in adult correctional centres

A vivid contrast exists between the problems of patients attending a medical out-patient clinic in a community general hospital and inmates attending sick parade in an adult correctional centre. Behavioural problems and drug dependence are two features

TABLE 11

ILLUSTRATIVE DATA ON SICK PARADE ATTENDANCE  
AT ADULT CORRECTIONAL INSTITUTIONS

(excluding jails)

(may not include parades conducted by nurse or correctional officer)

FOR THE YEAR ENDING MARCH 31, 1972

Institution	Average daily census	Sick parade (regular*)				Average per parade	Daily average as % of census
		** Fre- quency	Attendance				
			Total during year	March 1972	Average daily		
Vanier Centre for Women	90.53	3/d		485	10.16	2.5	11.22%
Burtch	140.72	3/wk	4,142	270	41	30	29.14
Burwash	485.75	1/d	6,927	548	28	27	5.76
Millbrook	192.8	1/d	5,556	536	15	15	7.78
Mimico	327	1/d	3,678	481	18	24	5.50
Monteith	85	3/wk	502	48	6	6.9	7.06
Thunder Bay	93	none	990	43			
A.G. Brown Clinic	72	1/d		48	4	4	5.56

\* Plus pill parades held generally 3 or 4 times daily.

\*\* 1/d - Sick parade held daily.

3/d - Sick parade held three times a day.

3/wk - Sick parade held three times a week.

Burtch: 2/d - nurse; 3/wk - medical officer.

Guelph: 1/d - no attendance data.

Rideau: 2/d - no attendance data.

Thunder Bay: no regular sick parade.

Source: Replies to Health Services Information Questionnaire, May, 1972.  
(Appendix 8)



of the correctional centres. The inmate can freely attempt to manipulate the physician most often with a view to obtaining "pills" or being excused from work.

Large numbers (see Table 11) attend physician's sick parades in correctional centres, averaging from 2.5 inmates per parade to 30 and, on a daily basis as a percentage of average census, from about 5% to 30%. The number varies with the frequency of the sick parade; it might be larger for in several institutions no enduring record is kept of inmates seen at nurses' morning and evening sick parades.

Obligatory attendance at sick parade includes new admissions, examination of inmates prior to transfer to other correctional institutions and for examination after an accident or injury.

Numerous conversations with correctional officers and inmates, physicians and nurses, indicate the following reasons for attending sick parade:

- (1) Illness - mental, emotional or physical.
- (2) Injury.
- (3) Emotional upset secondary to incarceration.
- (4) In search of pills.
- (5) Boredom, restlessness, desire to talk in sick bay waiting room with friend from another cell block.
- (6) Doing a "stall" to avoid work.

The percentage of inmates in (3), (4), (5) and (6) cannot be estimated for complaints and treatment are recorded most commonly by medical officers and diagnoses less frequently. It appears that not uncommonly minor forms of treatment, in effect a placebo, are

utilized as treatment for symptoms judged to be inconsequential or a "stall".

From time to time the physician and male nurse, very rarely the female nurse, must put up with abuse from inmates. Because physicians and nurses wish to remain and be identified as professionals, they will rarely lay a charge against an inmate for "stalling", for using sick parade for social purposes, or for verbal abuse, unless to a female nurse.

The repeated use of sick parades as a "stall", as a social meeting place, or in search of drugs, is judged to be a significant factor in discouraging some competent physicians and nurses who could well become committed to the care of inmates and to contributing to their rehabilitation efforts.

It should be noted that most of the foregoing observations apply to jails as well as to correctional centres and adult training centres (see also Pages 35, 36 and 37).

#### 4. Diseases and symptoms, and services recorded in institutions

Studies of the information recorded on the Medical Status Summary (Form 9801) and its supplement (Form 9802) were carried out in four correctional centres and one adult training centre by a Queen's University team directed by Drs. Steele and Kraus, and a University of Toronto team headed by Dr. le Riche (see Appendix 9). These studies were directed to obtaining illustrative quantitative information concerning the illnesses, complaints or health problems

for which inmates sought health care and the services provided or initiated by the health services staff - physicians, psychiatrists, nurses, dentists and, occasionally, correctional officers insofar as these were recorded on Forms 9801-02.

These documents showed a wide variety of health problems frequently expressed only as complaints or symptoms rather than diagnoses\*. The data resulting from these studies is presented in Table 12 for the most common diseases and symptoms and in Tables 13 and 14 for contacts and services respectively. More detailed information is given in Appendix 9.

As is evident from Table 12 the most prevalent condition is the common cold. Again, as in the jails, alcoholism and drug dependence are relatively common. Refractive errors at least seem to represent a specific diagnosis. The conditions resulting from accidental injuries - dislocations, sprains and strains, lacerations, bruises and the like - together account for nearly 10% of cases. The remaining health problems are recorded in essentially symptomatic terms; these include disturbance of sleep, nervousness and debility, headaches, abdominal swelling and pain, coughs and skin conditions.

There is some consistency apparent among the various centres but the relatively high frequency of post-admission entries at Millbrook is striking and this centre has the highest rate of contacts

\*It has been pointed out to the Committee that the Mimico Correctional Centre physician relies quite heavily on the diagnostic services of the local hospitals and that this will affect figures reported for various diagnostic procedures carried out by the physician in his examination of patients.

TABLE 12

MOST COMMON DISEASES AND SYMPTOMS RECORDED  
IN ADULT INSTITUTIONS (EXCLUDING JAILS)

Recorded on Forms 9801-02 at admission examinations and other contacts  
(Records may not include entries for screening or treatment by nurses or C.O.'s)

CASES\* - TOTAL FOR FIVE CENTRES\*

ICDA* Nos.	Disease, Injury or Symptom	Admission exams	Other contacts	Total cases	
				No.	%
303	Alcoholism	51	4	55	3.79
304	Drug dependence	60	-	60	4.13
370	Refractive errors (incl. vision loss)	18	15	33	2.27
460	Acute nasopharyngitis (common cold)	26	122	148	10.19
780.6	Disturbance of sleep	10	33	43	2.96
783.3	Cough	7	33	40	2.75
785.0 785.5	Abdominal swelling and pain	23	26	49	3.37
788.2	Rash, skin eruption, NES	23	55	78	5.37
790	Nervousness and debility, NES	25	25	50	3.44
791	Headache, pain in head, NES	13	37	50	3.44
830-848	Dislocations, sprains & strains	2	40	42	2.89
870-907	Lacerations and open wounds	3	39	42	2.89
920-929	Contusion and crushing with intact skin surface	9	48	57	3.93
	Total specified	270	477	747*	51.45
	Others	297	408	705	48.55
	Total Cases*	567	885	1,452	100.00

\*Notes:

1) Totals by Centres -

Inmates: Vanier 100; Brampton 100; Mimico 267; Millbrook 58; Guelph 115; Total 640

Cases: Vanier 217; Brampton 124; Mimico 501; Millbrook 138; Guelph 472; Total 1,452

2) Case = Inmate with a particular disease, injury or symptom.

Inmate counted only once for each such "diagnosis" recorded.

3) Most common = Disease, injury or symptom accounting for 2% or more of total cases.

NES = Not Elsewhere Specified.

4) ICDA Nos. = Eighth Revision International Classification of Diseases adapted for use in the United States. U.S. PHS publication No. 1693, Vol. 1 (1967); Vol. 2 (1969).

Source: Medical Record Field Studies (Appendix 9)

with the medical staff (Table 13). A substantial proportion of inmates have no recorded contact other than the admission examination. Some inmates do have many contacts during their stay.

Aside from routine physical examinations, measurements and tests on all, or nearly all, inmates in a centre, the most frequently recorded services (Table 14) are the administering of pills and other medications (16%), referral to a dentist and diagnostic radiography. Referral to a psychologist and/or psychometrist is apparently a general procedure at Guelph Correctional Centre. Other relatively frequent entries include the dressing of wounds, referral to an optometrist, to other medical specialists and dealing with glasses or other appliances, a recommendation for rest, the prescribing of a special diet, and hospital admissions and visits.



TABLE 13

DISTRIBUTION OF INMATES BY NUMBER OF MEDICAL  
CONTACTS IN ADULT INSTITUTIONS (EXCLUDING JAILS)

As recorded on medical record forms 9801-02

(Records may not include entries for screening or treatment by nurses or C.O.'s)

Number of contacts	Vanier C.C.	Brampton A.T.C.	Mimico C.C.	Millbrook C.C.*	Guelph C.C.	Total Inmates		Total contacts
						No.	%	
0	20	27	95	18	19	179	27.97	-
1	30	27	69	9	11	146	22.81	146
2	19	17	31	5	20	92	14.38	184
3	15	9	17	1	14	56	8.75	168
4	5	9	13	2	10	39	6.09	156
5	2	3	11	1	8	25	3.91	125
6	2	3	8	2	7	22	3.44	132
7	4	2	3	1	4	14	2.19	98
8	2	-	4	3	4	13	2.03	104
9	-	1	6	2	3	12	1.88	108
10	-	1	4	2	1	8	1.25	80
11	1	1	1	-	4	7	1.09	77
12	-	-	3	1	1	5	0.78	60
13	-	-	-	1	2	3	0.47	39
14	-	-	1	1	-	2	0.31	28
15-19	-	-	1	1	3	5	0.78	(85)
20-24	-	-	-	3	-	3	0.47	(66)
25-29	-	-	-	2	2	4	0.62	(108)
30-34	-	-	-	2	-	2	0.31	(64)
35-39	-	-	-	1	-	1	0.16	(37)
40-44	-	-	-	-	-	-	-	-
45-49	-	-	-	-	2	2	0.31	(94)
Total inmates	100	100	267	58	115	640	100.00	(1,959)
Total contacts	210	201	(562)	(393)	(593)			(1,959)
% of inmates with no contacts	20.00	27.00	35.58	31.03	16.52	27.97		
Average contacts per inmate	2.10	2.01	2.07	6.97	5.32			3.09
Total inmates with contacts	80	73	172	40	96	461		
Average contacts per inmate with contacts	2.62	2.75	3.21	10.1	6.38			4.29

\*Includes 32 contacts made by 8 of these inmates at the Guelph Neuro-Psychiatric Clinic.

Note: Bracketed figures - estimates based on mid-point of contact interval.

TABLE 14

HEALTH SERVICES RECORDED IN ADULT INSTITUTIONS (EXCLUDING JAILS)

(including admission examinations)

INMATES BY TYPE OF SERVICES FOR SELECTED CENTRES

(Records may not include entries for screening or treatment by nurses or C.O.'s)

Code No.	Type of Service	Vanier	Brampton	Mimico	Millbrook	Guelph	Total	
							No.	%
01	Routine physical exam on admission (incl. physical measurements)	100	100	267	58	115	640	23.61
02	Follow-up examination or recheck	5	-	4	1	-	10	0.37
04	Partial or incomplete examination	-	20	3	-	-	23	0.85
06	Psychiatric exam - "saw psychiatrist"	5	1	7	-	11	24	0.89
09	Other examinations and tests	-	-	-	7	19	26	0.96
11	Operation or surgical procedure	3	2	5	3	6	19	0.70
14	Diagnostic radiography	6	7	30	10	39	92	3.39
15	Physical medicine and rehabilitation (incl. soaks and compresses)	-	-	8	-	1	9	0.33
16	Prophylactic inoculation and vaccination (incl. tetanus and polio)	-	4	-	-	5	9	0.33
17	Dressing of wounds	4	12	17	-	-	33	1.22
18	Application of equipment (i.e. tensor, splint, cast)	1	6	7	-	-	14	0.52
21	Specimen or sample taken - urine	-	-	-	1	6	7	0.26
22	- blood	-	-	-	-	6	6	0.22
23	- sputum, nose or throat swab	-	-	-	-	17	17	0.63
26	Analysis or test result interpreted	501 <sup>1</sup>	4 <sup>2</sup>	279 <sup>3</sup>	-	-	784	28.92
27	Glasses, appliances and prostheses prepared or repaired	-	-	-	6	27	33	1.22
31	Consultation and advice	7	3	-	-	-	10	0.37
34	Rest recommendation	-	17	21	-	-	38	1.40
41	Referred to psychiatrist	-	-	-	-	10	10	0.37
42	Referred to other medical specialist	6	2	17	6	3	34	1.25
44	Referred to Dentist	2	2	60	10	68	142	5.24
45	Referred to psychologist, psychometrist	-	-	-	-	115	115	4.24
48	Referred to outside hospital	-	-	-	2	3	5	0.18
49	Referred to optometrist	11	10	14	-	-	35	1.29
51	Medication (pills & other) administered	75	59	161	32	94	421	15.53
61	Diet - special diet prescribed	9	6	24	6	6	51	1.88
62	Diet - special diet discontinued	-	-	-	-	3	3	0.11
71	Admitted to hospital (inst. or outside)	7	7	14	1	36	65	2.40
72	Visited in hospital	-	-	-	-	31	31	1.14
	Inmates with specified services	742	262	938	145 <sup>4</sup>	624 <sup>5</sup>	2,711	100.00
	Total inmates	100	100	267	58	115	640	

- Notes:
1. Includes VDRL, cervix, pregnancy tests, urinalyses, cultures and smears, for all 100 inmates of Vanier; and 1 blood test.
  2. Includes 1 VDRL, 2 urinalyses, 1 EEG at Brampton.
  3. Includes urinalyses on all 267 inmates at Mimico; plus 2 blood tests, 2 liver function tests, 1 glucose tolerance test, 4 EEG's and 3 ECG's.
  4. Total includes 1 assessment of fitness for duty or transfer, and 1 referred NES, at Millbrook.
  5. Total includes 1 complete or general physical examination; 1 biopsy; and 1 diagnostic endoscopy, at Guelph.

## V. THE TRAINING SCHOOLS

### 1. Basic data

The Annual Report for 1971 clearly states that "The major objective of a training school is to assist those assigned to its care to become better equipped to participate fully in the life of the community without resorting once again to unacceptable behaviour".

The Training Schools Act, 1965, states: "The purpose of a training school is to provide the children therein with training and treatment and with moral, physical, academic and vocational education".

There are now three training schools for girls plus a reception and diagnostic centre, and eight training schools for boys, along with White Oaks Village, Coldsprings Camp and Project D.A.R.E. A new reception and assessment centre for both boys and girls has just been officially opened at Oakville but it is not yet in operation.

These training schools with the associated centres and camps have under care at any time about 4,000 children, but most of these are on placement in the community, in their own homes, group homes, or foster homes. There are in residence in the schools about 1,200 children. It is with this resident population that the health services are mainly concerned.

The schools receive children under the age of 16 and may retain wardship to the age of 18. Most of the children, about 75% entering the schools are 14 and 15 years old (Table 15). There are more than twice as many boys as girls.

The basic data concerning the student/ward population of the training schools, summarized in Table 1, are given by school in

Table 16. Most of the schools have a capacity of 100 to 200 boys or girls and the overall occupancy (in residence/capacity) is about 70%. Occupancy varies, however, from about 46% for one boys' school to 80% for one girls' school. The average stay in the schools is 6 to 8 months.

The placement process must represent a considerable workload for the schools and, in fact, the placements outnumbered new admissions in 1971. The Annual Report, 1971, also indicates that there is a substantial proportion of returns from placement for various reasons. The returns represent about one-third of placements (not necessarily the same individuals) and over 80% are for "violation of placement terms" and by "court order". These may include repeaters.

TABLE 15

SEX AND AGE DISTRIBUTION OF TRAINING SCHOOL ADMISSIONS

YEAR ENDING MARCH 31, 1971

<u>Age</u>	<u>No.</u>	<u>%</u>
8	-	-
9	7	0.48
10	14	0.97
11	30	2.07
12	96	6.62
13	195	13.45
14	413	28.48
15	<u>695</u>	<u>47.93</u>
<u>Total</u>	<u>1,450</u>	<u>100.00%</u>
<u>Sex</u>		
Male	1,015	70.00%
Female	435	30.00%

TABLE 16

STUDENT POPULATION AND MOVEMENT - TRAINING SCHOOLS

YEAR ENDING MARCH 31, 1971

School	New admissions	Total under care	Placements from school	On School roll March 31 1971	April 2, 1972	
					In residence	Capacity
<u>Boys</u>						
Brookside	162	450	226	133	123	175
Cecil Facer					119	120
Glendale	128	259	138	117	53	115
Hillcrest	3	56	58	49	46	48
Pine Ride	230 <sup>1</sup>	477	329	171	143 <sup>2</sup>	220 <sup>2</sup>
St. John's	215	549	338	188	117	180
St. Joseph's	154	381	235	140	67	160
Sprucedale	110	254	139	140	82	115
White Oaks Village	13	94	22	61	37	60
Project D.A.R.E.					81	36
Total Boys	1,015	2,520	1,485	999	868	1,229
<u>Girls</u>						
Grandview	93	210	132	59	89	116
Reception & Diagnostic Centre	34 <sup>3</sup>	152	105	63	55	44
Kawartha Lakes	130	292	201	92	68	114
St. Euphrasia's (Elmcrest)	155	381	221	152	83	118
Trelawney House	23	44	26	14	16	20
Total Girls	435	1,079	685	380	311	412
GRAND TOTAL	1,450	3,599	2,170	1,379	1,179	1,641

<sup>1</sup>Includes in residence in reception centre - 12.

<sup>2</sup>Includes Coldsprings Camp - in residence 23; capacity 30.

<sup>3</sup>Includes in residence in reception centre - 10.

Source: Annual Report 1971 and Population Count (see Table 1).



2. Health services in training schools (based mainly on  
replies to the Health Services Questionnaire)

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Physical facilities

All but one of the 11 schools reporting (3 girls' and 8 boys' schools) had a hospital or infirmary although the beds set up varied from 1 to 12. These beds were located in 1, 2, or 4-bed rooms. Three schools mentioned having a designated room for isolation. Patient days in the hospital units varied from 77 to 368. None of the schools had operating room facilities.

One school only reported the occurrence of deaths during the year. This school had two deaths, neither occurred in the school; one boy was AWOL and the other was on placement. Both deaths were attributed to overdose of drugs.

Generally the schools did not provide office or examining room space for each physician or nurse but, rather, had a general medical room used for several purposes. In all but one school the dentist had a room or office with a dental chair.

Staff

All but one school had full-time nursing staff, generally three nurses. One school reported the use of nursing aides (one full-time and two part-time; one of the latter acts as medical records clerk). The schools employed part-time physicians and also employed the services of psychiatrists and dentists on a part-time basis.

### Laboratory and other diagnostic services

A great variety of diagnostic services are provided but there is no consistent pattern. Many schools made use of community hospital and local or district public health resources for diagnostic tests. Most schools carried out routine blood tests for syphilis and urinalysis for sugar and albumin. Either miniature or large film chest x-rays were taken for tuberculosis detection, mainly by the health unit or provincial chest clinic. Routine vision and hearing tests were commonly conducted by the nurses (Snellen chart and whisper test usually). The occasional audiometer, ECG, or EEG tests were reported. Height and weight measurements were, of course, routinely taken.

### Health care records

All but one school uses the Medical Status Summary Form 9801-02; this school prefers another type of record. The form is initiated at the time of the admission examination; entries are made by the medical officer and nurse. One school mentioned occasional entries by the dentist. The forms are filed alphabetically in the doctor's office, medical room or nurse's office or station. Wards do not handle the records. The records are kept in the school when the student is on placement or wardship is terminated but go with the student on transfer. Only two schools retain a copy in this case.

The schools generally do not use the Transfer to Hospital or Accident and Injury Forms but have forms to serve the same purpose.

The schools use health record forms to a greater extent than do adult institutions. Forms include dental charts, drug records, x-ray reports, nurses' notes. Several schools provided sets of their report forms and some of these were quite comprehensive.

Seven schools provided statistics of transfers to hospital. Seven schools reported 24 transfers during March 1972, the frequency being: one - 2 schools; three - 2 schools; four - 1 school; six - 2 schools. For the period January - March 1972, or a recent three-month period, 22 transfers from seven schools were distributed by purpose as follows:

Transfers to hospital

<u>Purpose</u>	<u>Schools by number of cases</u>				<u>Total cases</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	
(a) Diagnosis	4	1	-	-	6
(b) Treatment	1	1	-	-	3
(c) Operation	1	1	2	1	<u>13</u>
<u>Total</u>					<u>22</u>

Drug control

Drugs are generally kept in a locked cabinet or cupboard in the medical room or nurse's office.

First aid

All schools reported having some emergency facilities or equipment but these varied from school to school and included: oxygen masks and other resuscitation equipment, splints, stretcher and lavage tray.

Sick parades at training schools

Eight of the 11 schools reported having a regular sick parade, all with sick parades were boys' schools; one had pill parades only and another had pill parades plus sick parades on request. The regular sick parades with frequency varying from one to four per day were generally held in the hospital or medical officer's office. Interviews and examinations were reported as being conducted in private except in two schools which gave a qualified affirmative answer.

Nurses screen the students' sick parades in all but one school. The medical officer is advised of the health problem or complaint but apparently not the identity of those screened. Only two schools gave numbers of those seen by the nurses only and by the doctor; the ratio nurse/doctor was 4.75 for one and 3.0 for the other. Entries are not generally made on Form 9801 for sick parade attendances but a record is kept in a day book or card index in several schools.

Some data were given for sick parade attendance and these indicate that attendance per parade was generally between 5 and 20 with corresponding percentages of average daily population being 10-20%. Two schools had much higher attendance representing 58% and 81% of average daily population. The extent to which there are repeaters in the sick parades is not known however.

### 3. Diseases and symptoms and services recorded in training schools

The teams from Queen's University and the University of Toronto (Appendix 9) examined Medical Status Summary Forms 9801-02 in three training schools - Grandview, Hillcrest and Pine Ridge. The resulting illustrative data are shown in Tables 17-19 inclusive and further details are given in Appendix 9.

The list of most common diseases and symptoms for the training schools (Table 17) differs somewhat from those for the adult institutions although the common cold and drug dependence are evidently among the predominant personal health problems in institutions and schools alike. The relatively high proportion of neurotic symptoms coded as anxiety or depression is of major concern. The considerable incidence of accidents resulting in dislocations, sprains and strains, lacerations and open wounds, and contusions and crushing including bruises, which together account for nearly 14% of the cases, might well be a signal for investigation of the accident rate and circumstances. The prevalence of warts and of refractive errors is interesting and not surprising in this age group. The other items in the list include such symptoms as dizziness, abdominal swelling and pain, skin rash and headaches.

Again, as in jails and other adult correctional centres, there is a preponderance of symptoms rather than diagnoses. In the training schools a high proportion of these cases occurs subsequent to the admission examination (Table 17) and there is a high ratio



TABLE 17

MOST COMMON DISEASES AND SYMPTOMS RECORDED IN TRAINING SCHOOLS

Recorded on Forms 9801-02 at admission examinations and other contacts

(Records may not include entries for screening or treatment by nurses or supervisors)

CASES\* - TOTAL FOR THREE TRAINING SCHOOLS\*

ICDA No.	Disease, injury or symptom	Admission exams	Other contacts	Total cases	
				No.	%
079.1	Warts	3	14	17	2.04
300.0	Anxiety and other neuroses NES	9	13	22	2.63
300.4	Depression (neurosis)	6	14	20	2.40
304	Drug dependence	55	11	66	7.90
370	Refractive errors (incl. vision loss)	10	17	27	3.23
460	Acute nasopharyngitis (common cold)	17	77	94	11.26
780.5	Vertigo, dizziness, giddiness	5	14	19	2.28
785.0	Abdominal swelling and pain	7	27	34	4.07
785.5					
788.2	Rash, skin eruption NES	11	20	31	3.71
791	Headache, pain in head NES	6	25	31	3.71
830-848	Dislocations, sprains and strains	1	21	22	2.63
870-907	Lacerations and open wounds	4	34	38	4.55
920-929	Contusion and crushing with intact skin surface	4	51	55	6.59
	Total specified	138	338	476	57.00
	Others	137	222	359	42.99
	Total cases	275	560	835	99.99%

\*Notes:

1) Total by Schools - Wards: Grandview 100; Hillcrest 69; Pine Ridge 68; Total 237  
Cases: " 330; " 273; " " 232; " 835

2) Case = Ward with a particular disease, injury or symptom.

Ward counted only once for each such "diagnosis" recorded.

3) Most common = Disease, injury or symptom accounting for 2% or more of total cases.

4) NES = Not Elsewhere Specified.

5) ICDA Nos. = Eighth Revision International Classification of Diseases adapted for use in the United States. U.S. PHS publication No. 1693, Vol. 1 (1967); Vol. 2 (1969).

Source: Medical Record Field Studies (Appendix 9)

of contacts and lower proportion of persons with no contacts than in adult institutions (Table 18). This higher incidence of attendance at sick parade may reflect the fact that children rather than adults are involved, that children have longer stays than adults, or that more adequate medical services are provided in training schools.

The data regarding services provided (Table 19) do seem to suggest a greater use and range of diagnostic tests and a greater use of specialist referrals and of preventive procedures, but the picture is quite different for the three schools. The administering of pills and other medications, however, is among the most common services in the training schools.

TABLE 18

DISTRIBUTION OF STUDENTS BY NUMBER OF  
MEDICAL CONTACTS IN TRAINING SCHOOLS  
(excluding admission examinations)

AS RECORDED ON MEDICAL RECORD FORMS 9801-9802

(Records may not include entries for screening or treatment by nurses or supervisors)

Number of contacts	Grandview	Hillcrest	Pine Ridge	Total students		Total contacts
				No.	%	
0	4	4	4	12	5.06	0
1	15	13	5	33	13.92	33
2	23	10	16	49	20.68	98
3	20	9	14	43	18.14	129
4	11	7	8	26	10.97	104
5	11	9	4	24	10.13	120
6	6	4	4	14	5.91	84
7	3	4	4	11	4.64	77
8	2	3	4	9	3.80	72
9	3	2	2	7	2.95	63
10	-	-	-	-	-	-
11	-	2	1	3	1.26	33
12	1	1	1	3	1.26	36
13	-	-	1	1	0.42	13
14	1	1	-	2	0.84	28
Total students	100	69	68	237	99.98	
Total contacts	346	275	269			890
% of students with no contacts	4.00	5.80	5.88		5.06	
Average contacts per student	3.46	3.99	3.96			3.76
Total student with contacts	96	65	64	225		
Average contacts per student with contacts	3.60	4.23	4.20			3.96

Source: Medical Records Field Studies (Appendix 9)

TABLE 19

HEALTH SERVICES RECORDED IN TRAINING SCHOOLS

(including admission examinations)

WARDS WITH SPECIFIED SERVICE - BY SCHOOL

AS RECORDED ON MEDICAL RECORD FORMS 9801-9802

(Records may not include entries for screening or treatment by nurses or supervisors)

Code No.	Service	Grand-view	Hillcrest	Pine Ridge	Total	
					No.	%
01	Routine physical examination on admission (incl. physical measurements)	100	69	68	237	14.75
02	Follow-up examination or recheck	9	7	-	16	1.00
04	Partial or incomplete physical examination	2	1	-	3	0.19
06	Psychiatric exam. - "saw psychiatrist"	-	69	16	85	5.29
07	Neurological examination, complete	-	-	1	1	0.06
08	Skin immunity & sensitization tests (including TB test)	100	-	1	101	6.29
09	Other exams & tests (for eyes mostly)	-	-	6	6	0.37
11	Operation or surgical procedure	10	2	9	21	1.31
14	Diagnostic radiography	15	69	11	95	5.91
15	Physical medicine & rehabilitation (incl. soaks and compresses)	-	29	-	29	1.80
16	Prophylactic inoculation & vaccination (including tetanus and polio)	30	1	47	78	4.85
17	Dressing of wounds	9	27	-	36	2.24
18	Application of equipment (tensor, splint, cast)	3	14	-	17	1.06
21-23	Specimen or sample taken for diagnostic test - urine; sputum; nose or throat swab	-	-	3	3	0.19
26*	Analysis or test result interpreted	113	281	-	394	24.52
.2	Liver function test	(1)	-	-	(1)	(0.06)
.6	Pregnancy test	(3)	-	-	(3)	(0.19)
.9	EEG	-	(5)	-	(5)	(0.31)
27	Equip. dispensed - glasses or other appliances & prostheses prepared or repaired	-	-	20	20	1.24
31	Consultation and advice	10	1	-	11	0.68
34	Rest recommendation	-	6	-	6	0.37
41	Referred to psychiatrist	-	-	16	16	1.00
42	Referred to other medical specialist	-	4	14	18	1.12
44	Referred to dentist	5	69	24	98	6.10
45	Referred to psychologist, psychometrist	-	-	63	63	3.92
48	Referred to outside hospital	-	-	3	3	0.19
49	Referred to optometrist	27	19	-	46	2.86
51	Medication (pills & other) administered	74	55	41	170	10.58
61	Diet - special diet prescribed	4	5	2	11	0.68
62	Diet - special diet discontinued	-	-	1	1	0.06
71	Admitted to hospital (inst. or outside)	9	12	1	22	1.37
TOTAL		520	740	347	1,607	99.99

\*Included are: Blood tests, VDRL, urinalyses, cultures and smears for all (69) wards at Hillcrest; cultures and smears were also reported for all (100) at Grandview which also showed 8 urinalyses and one throat swab interpreted.

## VI. THE MINISTRY HEALTH CARE SYSTEM

### Opening Statement

Conspicuous among the results of the Committee's labours is the high opinion in which it holds the staff of the Ministry, the Administrative and Executive groups at Headquarters and in jails, training schools and adult correctional centres across the province. The Committee is deeply conscious of the integrity and sincere motivation of the correctional staff led by the superintendents and their increasing commitment to assisting individual inmates and wards to rehabilitate themselves. In the course of the study the Committee became conscious of evidence of the stressful way of life of superintendents of larger jails, adult correctional centres and some training schools.

Advice and information has been sought from the consultants. Individual consultations and group discussions have taken place in addition to group consideration of each consultant's report. Without these reports attached as appendices, the report of the Committee would not in any way show adequately the complex nature of the problems of health services in the Ministry or the major efforts directed toward their solution.

The Committee is most sincerely and deeply appreciative of the magnitude and generosity of their contributions; much of what may turn out to be useful and helpful is largely attributable to the



consultants and to Gordon Josie. For better or worse, the responsibility for the judgments, conclusions and recommendations in this report is entirely and squarely that of the Committee; this is in keeping with the design of the Minister.

1. Policy and organization - Headquarters and Ministry-wide

a) Objectives and program

Assumption of responsibility by the Ministry for the jails in 1968 and the accelerating development of rehabilitation as a primary objective of the Ministry have not yet been matched by redevelopment of the health services. In the assessment of existing health services and in considering possibilities for improvement, the Committee has had in mind -

- (i) the Ministry purpose "...to attempt to modify the attitudes of those in its care and to provide them with the kind of training and treatment that will afford them better opportunities for successful personal and social adjustment in the community;"
- (ii) the statutory responsibility of each superintendent for the care of his inmates or wards;
- (iii) a medical officer's statutory responsibility to "...control and direct the medical and surgical treatment..." of all inmates or wards;
- (iv) the evident Ministry policy to provide "...medical facilities and services which are comparable to those available to the rest of the general public" (Medical Services Manual, MS:02:00), or, "similar to those available in the community" (Annual Report 1971, page 26).

This enquiry was directed to establishing, among other things (Page 4), whether or not the system of health care could be expected

"...to provide decent, adequate and effective health services..."  
and to make "...the maximum possible contribution to students and  
adult inmates in their effort to rehabilitate themselves..."

A comprehensive health care program may be described in  
terms of measures directed to -

- (i) Prevention - which will include
  - health education of inmates and wards  
and of staff;
  - screening - especially of first incarcerates;
  - providing a healthful environment.
- (ii) Diagnosis - through clinical examinations,  
tests and measurements.
- (iii) Treatment - which may be ambulatory or bed care.
- (iv) Rehabilitation - which should include
  - classification after health assessment and  
treatment as required, and
  - individual program planning and counselling  
with appropriate directives concerning health,  
fitness and remedial activities.

From the standpoint of the Government and the Ministry, these  
measures must be developed in the light of the practical criteria of  
services generally available to people in the community and the  
resource requirements. From the standpoint of the staff, the health  
services system must provide a satisfying professional role. All  
of these, Ministry, staff, wards and inmates, will be concerned with  
the availability of health care of optimum quality.

Study and analysis of all data accumulated and of the reports  
of the consultants and of visits to training schools and adult institutions  
have led the Committee to certain main conclusions and recommendations

which fall into the following four main groups and the remainder of this report is organized on this framework.

A. Conclusions and recommendations regarding Ministry health services, policy and organization (Section VI) particularly including:

- a) A new policy and organization for the health services directorate and consultants who will be responsible for the system of delivery of health care and the quality of the Ministry's health services;
- b) Comprehensive health care by a multi-disciplinary team;
- c) A new relationship to universities, health sciences complexes, university affiliated hospitals and satellite hospital centres;
- d) Planned program budgeting for health services by the Executive Director of Health Services;
- e) Payment of doctors, nurses and dentists and specialized allied health professionals in keeping with civilian rewards of practice; compensation for professional isolation in correctional institutions must be included.

B. The second group of conclusions and recommendations (Section VII) identifies existing health services problems and deficiencies. Solutions are proposed for the consideration of the Minister.

C. Research (Section VIII).

D. Conclusions and recommendations concerning Inter-Ministry studies necessary for the short and longer terms (Section IX).

b) Executive Director of Health Services

(1) The position of an Executive Director of Health Services must be established. The Executive Director of Health Services must be responsible directly to the Deputy Minister and through him to the Minister for the executive management of the Ministry system of delivery of health care; for the collaborative integrated multidisciplinary operation of the Ministry comprehensive health services, i. e.

- (i) for preventive, diagnostic and treatment services, including medicine, pediatrics and psychiatry services; nursing and dentistry; clinical psychology and social services (medical and psychiatric);
- (ii) for the proper contribution of health care to the efforts of the individual to rehabilitate himself/herself;
- (iii) for the contribution of health care to the Ministry treatment and rehabilitation program designed to promote socially and legally acceptable behaviour.

(2) The maintenance of proper quality of professional health services in each correctional institution and school by the three primary health professions (medicine, nursing and dentistry), the allied health professions and auxiliary health personnel, must be the responsibility of the Executive Director of Health Services. To the extent that specialized members of the psychological and social services are engaged in health care they will be the administrative responsibility of the Executive Director of Health Services, e. g. social workers (medical and psychiatric) and clinical psychologists.

Each member of the primary or allied health professions working in training school, jail, or adult correctional centre, shall be responsible to the Executive Director of Health Services for the proper discharge of his professional and/or technological responsibilities relating to all aspects of health care (preventive, diagnostic and therapeutic) and to rehabilitation.

(3) The Executive Director of Health Services shall be empowered to require and to receive directly reports from appropriate members of the health professions. These may be on a regular and special enquiry basis concerning the health problems among adults and wards. Such problems may be preventive, diagnostic and therapeutic, among adults and wards and concerning the contribution of the primary and allied health professions to rehabilitation.

(4) The Executive Director must endeavour to ensure that members of the three primary health professions (medicine, dentistry and nursing) discharge their professional health care responsibilities in a legal and ethical manner and in keeping with the policies and regulations of the governing colleges and with the Health Disciplines Act, presently under development as "Legislative proposals for Health Disciplines Act", June, 1972.

(5) The Executive Director must ensure that each member of each profession engaged in the diagnosis and treatment of health problems - doctors, nurses, psychologists, social workers and



dentists - is provided with facilities enabling him/her to discharge decently and effectively his professional responsibility; to ensure that every reasonable measure is taken to ensure the best possible quality of care for the individual inmate or student/ward.

(6) At the present time no minimum standards for examining facilities or medical equipment have been developed. The allocation of space for the institutional health centre is largely decided on an individual institutional basis in jails, existing correctional centres and training schools. Administrative and fiscal approval of facilities and equipment at Headquarters needs to be supported by effective medical, dental, nursing and allied health input regarding the needs for health services, for students/wards and inmates, through an Executive Director of Health Services.

(7) The Executive Director should develop and manage the Ministry budget for health services in keeping with government policy (see Planned Program Budgeting, Pages 102 and 103).

(8) All recommendations to the Ministry for appointments to the health services staff, doctors, dentists (who will be mainly part-time employees and not civil servants), nurses, allied health professionals and auxiliary health personnel, should be made only through and by the Executive Director of Health Services (see Health Services Advisory Board and Ministry Consultants):

- (i) The Executive Director must be advised by the appropriate Ministry consultant who would be responsible for developing an agreed upon

nomination or nominations. Where affiliation exists with the university, its regional health sciences complex or satellite health centre and affiliated hospital, a mutually agreed upon nomination must be developed. In the absence of an agreement or formal affiliation, consultation regarding nomination(s) should be sought with the appropriate general hospital.

- (ii) The concurrence of the superintendent of the training school or adult institution in the appointment of professional staff remains a requirement.

(9) Desirable personal attributes of Executive Director of Health Services: The Executive Director of Health Services should possess especially the qualities of leadership, managerial skills and humane tolerance. He must have understanding of the biological-medical, psychiatric, social and psychological approaches to illegal behavioural disorders; he must understand the need of the individual inmate or ward for ethical responsible medical, dental and health care. Wards' and inmates' medical problems may or may not be associated with crime and with or without violence. Medical problems may result from custody or from the combined stress of custody and of treatment in the therapeutic milieu/community.

The Executive Director should be a qualified and licensed physician who has the attributes outlined in the preceding paragraph. In the event that a suitable licensed physician is unavailable and a non-physician with the qualifications stated above is available, then he/she may be appointed as Executive Director of Health Services.

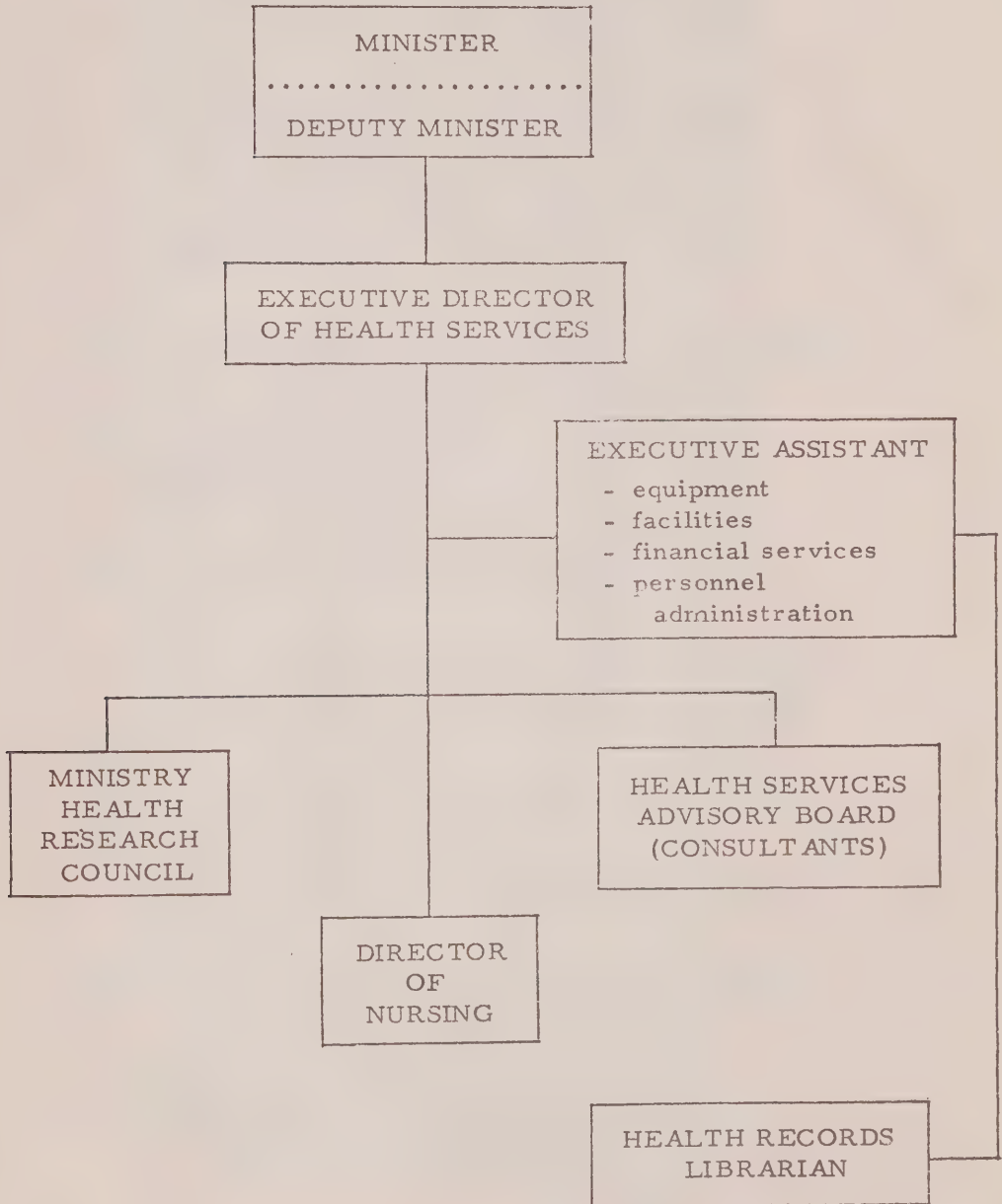
(10) The Executive Director of Health Services should be appointed upon the advice of a Ministerial Search Committee, not larger than seven members, chaired by the Deputy Minister and consisting of the following members:

- Deputy Minister;
- One member of the Ministry staff;
- One member who shall not be a civil servant;
- One member appointed by the Minister upon the recommendation(s) of a university nominated by the Minister;
- One member appointed upon the recommendation(s) of the Provincial Secretary for Social Development;
- One member appointed upon the recommendation(s) of the Provincial Secretary for Justice;
- One representative of the Civil Service Commission.

(11) The Executive Director of Health Services should be advised by a Health Services Advisory Board, chaired by him and consisting of Ministry consultants (see Page 92). It is highly probable, and for most purposes desirable, that under the chairmanship of the Executive Director, the Board will divide and function frequently as separate committees for training schools and for adult institutions.

MINISTRY OF CORRECTIONAL SERVICES

MAIN OFFICE ORGANIZATION FOR HEALTH SERVICES



c) Other Headquarters' staff

- (i) The Executive Director of Health Services should be assisted by a full-time Director of Nursing;
- (ii) The Consultant in Dentistry should serve also as a coordinator of dental services, initially at least on a half-time basis;
- (iii) The Executive Director will require an Executive Assistant. The responsibilities of this office should include assisting the Executive Director of Health Services with all matters pertaining to equipment, facilities, financial services and personnel administration.
- (iv) Health Records Librarian - The need to develop a new system of managing the health records of children and adults requires the services of a Health Records Librarian trained in contemporary systems of data management; in particular the problem-oriented health record. The Records Librarian must work in collaboration with Ministry research and systems officers.

d) Health Services Advisory Board - Consultants

The Ministry and the Executive Director of Health Services require the ongoing support of consultants widely recognized for their professional attainments and clinical competence. Of paramount importance is the need for the consultants to contribute to the ongoing improvement of the system of health care delivery throughout the Ministry, to consult actively in their professional fields and so contribute to the quality of the health care, preventive and curative, provided for the individual inmate or student.

The following conditions of appointment of a consultant should require him/her:



- (i) to have a major responsibility and appointment outside the Ministry in a university or hospital;
- (ii) to serve the Ministry five half-day sessions per week, save the consultant in nursing and the consultant in research. The consultant in nursing should serve two half-day sessions per week. (A full-time Director of Nursing is recommended.) The consultant in research should evolve his commitments in relation to the development and financial support of research. The Committee believes he should attend, for some period, the meetings of the Health Services Advisory Board to develop an appreciation of operational problems;
- (iii) to undertake to visit regularly training schools and/or adult institutions to aid in the identification and solution of clinical and administrative problems, in consultation with his colleagues. His knowledge, experience and skills should contribute to the development of easy professional and administrative interrelationships;
- (iv) to develop recommendations for the Executive Director of Health Services regarding all aspects of professional policy and practice (including personnel) relevant to their particular discipline through the "Health Services Advisory Board";
- (v) to create a channel of communication regarding professional and associated administrative problems to and from his colleagues in training school or adult institution and the Executive Director of Health Services;
- (vi) to promote seminars and meetings, sponsored and supported by the Ministry with the full participation of the professional Ministry staff in his own scientific discipline and forensic field as well as interdisciplinary meetings; to help develop health education of correctional and teaching staff;

- (vii) appointment of a Ministry consultant should be made only upon the recommendation of a Ministerial Search Committee established for each consultant and appointed by the Minister with the Executive Director of Health Services as chairman. It should consist of not more than seven people. The committee should include -

- . The Deputy Minister or his representative
- . The Executive Director of Health Services
- . One member of the Ministry staff
- . One non-civil servant
- . One member appointed upon the advice of a university chosen by the Minister
- . One member should be appointed from nomination(s) of the Ministry of Health
- . One member of the Ministry of Correctional Services' health services staff.

The committee must consult widely with appropriate Ministry health services staff;

- (viii) appointments of consultants should be for a term of five years requiring reappointment annually, upon the recommendation of the Executive Director of Health Services; the appointment should be renewable for only one additional three-year term by mutual agreement between the Ministry, upon the recommendation of a search committee, and the consultant.

The membership of the Board will consist of the following Ministry consultants:

Chairman	- Executive Director of Health Services
Pediatrician	Social Worker (medical or psychiatric)
Physician	Dentist
Psychiatrist (child)	Nursing, Director of Nursing ex officio
Psychiatrist (adult)	Consultant in Research
Psychologist (child)	Nurse, Consultant
Psychologist (adult)	Drug Addiction Consultant

and the Coordinator, Treatment and Training Services (non-health) ex officio.

The purpose and functions of this Board should be:

- (1) (i) To ensure that all Ministry wards in training schools and all inmates of adult correctional institutions, centres, camps, etc., receive the best possible health care services;
- (ii) To supervise the health care services of the Ministry;
- (iii) To recommend all appointments to the medical, dental and nursing staff and allied health professional staff engaged in health care, save Ministry consultants.

(2) To provide a means whereby problems of health services administration in the Ministry may be discussed upon the initiative of the practicing professional Ministry staff, of members of the Health Services Advisory Board, of the Executive Director of Health Services or of the Deputy Minister.

(3) To approve, and from time to time propose, directives by the Executive Director of Health Services regarding health services. These will be provided for adult inmates and students/wards by doctors, dentists, nurses, specialized social workers (medical and psychiatric) and psychologists, and other allied health personnel.

(4) To ensure continuing educational opportunities for all Ministry staff engaged in health services and endeavour to advance their individual professional status.

(5) To require that the Health Services Advisory Board shall make recommendations before any executive action is taken concerning the dismissal or suspension of any member of the health care staff (doctor, dentist, nurse or allied health professional) upon evidence of professional incompetence, negligence, or any form of professional

misconduct, or for conduct unbecoming a member of the medical staff, nursing staff, dental staff, or allied health professional staff, e.g. psychologists or social workers (medical or psychiatric), engaged in the system of delivery of health care.

(6) To advise the Executive Director of Health Services and Deputy Minister regarding the suitability of space, facilities and equipment proposed and planned for use of, or in use by, medical, dental, nursing and allied health professional services.

(7) To review, as a prerequisite to establishment, every new treatment service or new unit, school or institution, involving the health services and to make recommendations for the health services personnel, facilities and equipment necessary to ensure the best possible health care.

e) Health Services Advisory Board - Institutional

In each training school, adult correctional centre and regional detention centre and in large jails, a multidisciplinary Health Services Advisory Board should be established within the institution or school.

(1) The Chairman of the Board should be appointed by the Executive Director of Health Services, upon the recommendation of the Health Services Consultant Board, guided by the same terms of reference as were defined for the Executive Director of Health Services. The concurrence of the superintendent of training school or adult institution is a requirement.

(2) The functions of the Health Services Advisory Board -

Institutional, include the responsibility of developing and maintaining for inmates or student/wards a unified collaborative, comprehensive health service. To this end it is necessary for the Board -

- (i) to ensure that effective interdisciplinary meetings occur at regular and appropriate intervals;
- (ii) to include at the meetings as members of the Institutional Health Services Advisory Board either the senior physician, psychiatrist, dentist and nurse and specialized allied health professional or, alternatively, the entire health services staff; in either case the superintendent or his deputy and the individual specially concerned with drug (including alcohol) abuse and, at a training school, the senior teacher or his deputy;
- (iii) to ensure that unified comprehensive problem-oriented health records are developed in keeping with Ministry policy and which are readily available in their totality but only to the primary health professionals and allied health professionals;
- (iv) to ensure that only clinical conclusions regarding students or inmates resulting from the investigation by the health services are communicated to the correctional staff and educational staff. This must be done in the most helpful possible fashion to aid in the education of the individual and to assist the student or inmate with his rehabilitation;
- (v) to advise the superintendent of training school or adult institution regarding the administrative and professional aspects of health services in the training school or adult institution through the Chairman of the Board.

(3) It is recommended that the part-time pediatrician, physician or psychiatrist be enabled to serve as chairman of the Health Services Advisory Board and Institutional Director of Health Services.



(4) It is recommended that the Health Services Advisory Board in adult centre or training school must function so as to support -

- (i) the ethical and legal physician-nurse-patient, physician-psychologist-patient, physician-social worker-patient relationships;
  - (ii) the appointment of a physician-in-chief for the institution, who may be a general physician, pediatrician or psychiatrist serving the Ministry on a full-time or part-time basis;
  - (iii) the development of new strategies in any professional discipline or group of professional disciplines;
  - (iv) full interdisciplinary communication and cooperation in the interests of providing the best possible health services and contribution to the rehabilitation of the well, sick or injured individual and of the individual with behavioural problems or psychiatric illness.
- f) Comprehensive health care in the Ministry by multidisciplinary team: Health care program for all Province of Ontario

Redevelopment of the health services must be multidisciplinary and collaborative and include the biological-medical, psychiatric, nursing, dental, pharmacological, psychological and social approaches to sickness, to behavioural disorders and to rehabilitation. To be effective and to provide such a truly comprehensive health service all these professional services must function collaboratively in developing policy and in practice. The Ministry itself must provide directly certain health services. These include comprehensive primary health care for the ambulatory in the health centre; sick bay care must be provided for a student in training school and for an inmate of an adult

correctional institution or centre; for residents of the Alex G. Brown Memorial Clinic; for inmates of reclamation units for alcoholics and of the Guelph Neuro-Psychiatric Clinic, and of jails and regional detention centres.

The Ministry of Correctional Services comprehensive primary health care program must be regarded as part of the health care program for the people of Ontario; in fact, the Ministry utilizes the following health resources for the care of students/wards and inmates.

(1) the Ministry of Health, e. g.

- Mental Health Division
- Ontario Psychiatric Hospital
- Public Health Division
- Venereal Disease Control Section
- Local Health Services Branch - Public Health Dentistry
- Psychiatric Clinic of Juvenile Court of Toronto, paid for by the Ministry of Health through the Clarke Institute of the University of Toronto

(2) - General hospitals  
- Children's hospitals  
- Special hospitals

(3) the Ministry of Community and Social Services, e. g.

- Rehabilitation Services Branch - Sheltered Workshops for Mental Retardates.

g) New relationship with universities, health sciences complexes - colleges of applied arts and technology

The universities of Ontario have potential resources of knowledge and skill which could be made available to the Ministry on a "contract" basis, e. g. -

- (i) Schools of social work;
- (ii) Departments of psychology;
- (iii) Health sciences complexes, including faculties of medicine, dentistry, nursing, rehabilitation therapy, schools of dental technology, speech therapy, schools of hygiene, psychiatric facilities, etc.

The colleges of applied arts and technology already include training in nursing, child care, laboratory technology, etc., and represent a major opportunity for collaborative development of allied health personnel.

Affiliation with one university and/or regional health sciences complex\*

In a training school, jail, correctional centre or clinic of appropriate size and complexity, the Ministry should seek affiliation with one university and/or its university regional health sciences complex, satellite centre or affiliated Ontario Psychiatric Hospital. For example, the Committee concludes that from the outset the Ministry should seek affiliation of Oakville Reception and Assessment Centre with the University of Toronto and with the Hospital for Sick Children, on a formal basis leading to an agreement between the Ministry on the one hand and the University of Toronto and Hospital for Sick Children on the other hand. The involvement should be sought specially of the Clarke Institute, the Department of Psychology

\*Since this Report was written, the Association of American Medical Colleges, Division of Operational Studies, has published a Datagram, "The Medical College and Prison Health Care." Journal of Medical Education, Vol. 47, pp. 831-832, October 1972. (Appendix H)

and the psychiatric clinic of the Juvenile Court in Toronto, and other relevant and potentially supporting components of the University of Toronto.

The Committee recommends that the Ministry should seek affiliation with:

McMaster University, and its Health Sciences Complex and Thunder Bay Satellite Centre	- White Oaks Village and Sprucedale, Hagersville - Grandview School, Galt - Hillcrest School, Guelph - Guelph Correctional Centre - Hamilton Jail - Thunder Bay Jail and Correctional Centre
University of Toronto	- Pine Ridge School, Bowmanville - Oakville Reception and Assessment Centre - Vanier Centre for Women, Brampton - Brampton Adult Training Centre - Alex G. Brown Memorial Clinic, Mimico - Mimico Correctional Centre - Toronto (Don) Jail (St. Michael's Hospital) - Central Ontario Reception and Assessment Centre (adult) - (?) Brampton
Queen's University, and its Health Sciences Complex and Sudbury Satellite Centre	- Quinte Regional Detention Centre, Napanee - Millbrook Correctional Centre  - Burwash Correctional Centre
Ottawa University	- Rideau Correctional Centre, Burritt's Rapids - Ottawa-Carleton Regional Detention Centre, Ottawa - St. Joseph's School, Alfred
University of Western Ontario	- London Jail - Windsor Jail

This recommendation should not be taken to mean that any university should be asked to assume responsibility either for staffing or management of the health services of a Ministry institution. The relationship conceived by the Committee more closely resembles the relationship between an affiliated Ontario Psychiatric Hospital and its university health sciences complex.

In each instance financial support of the university health sciences complex is recommended to establish new posts for doctors who will also serve the Ministry.

h) Governing Colleges of Medicine, Dentistry,  
Nursing and of allied health professionals

At the present time the health services of the Ministry are exposed to public and professional scrutiny by means of an inquest into every death of an inmate of an adult correctional institution or student in training school, whether in hospital or correctional institution. Public Health inspections are carried out by the local Health Services Branch of the Ministry of Health of Ontario.

In addition, so that the public interest may be fully served and protected, the governing colleges of the primary health professions (medicine, dentistry and nursing) should recognize and undertake responsibility for students in training schools and inmates in adult correctional institutions, as they do for the other citizens of Ontario.

This would contribute to the ongoing improvement of health services by the maintenance of the standards of ethical professional practice. The colleges referred to are the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario and the Royal College of Dental Surgeons of Ontario. It is important to Ministry and inmate that not only should complaints concerning quality, e. g. of medical services, be investigated, but that justice should be seen to be done. The colleges should acknowledge a clear mandate; they must be provided with the financial means to investigate to the full extent the individual college judges necessary, complaints concerning professional health services in the broad fields of medicine, dentistry and nursing.

As colleges for the allied health professions are developed, e. g.



under a Health Disciplines Act, they too should have the same responsibilities and concern for the health service activities (treatment services) of their constituent members in the Ministry of Correctional Services.

In the following, while referring directly to medical services, it is intended to apply equally to dental and nursing services and eventually to health services (treatment services) by allied health professionals.

(1) A complaint by an inmate, or student, or relative, regarding medical services lodged through Ministry channels, would be investigated by the Executive Director of Health Services and his staff on behalf of the Minister. In the event that the complainant was dissatisfied with the decision of the Ministry, he/she should have the right to request a review by a Board established by the College of Physicians and Surgeons of Ontario. The College should be provided with the Department's complete health record of the complainant and, if necessary in the opinion of the Board, with the complete Ministry general file concerning the complainant. In the event the Board judged it necessary to investigate further the individual's complaints concerning medical services, the Board should have the authority to interview the complainant as well as any Ministry personnel it judged fit to question.

The College of Physicians and Surgeons of Ontario, should report to the Minister of Correctional Services and to the complainant.

(2) Complaints regarding medical services made to persons outside the Ministry by an inmate or student or relative and not made

through Ministry channels, (e.g. Member of Parliament, the press, lawyer, priest, physician) would be referred, as at present, to the Minister for investigation as if the complaint had been made through Ministry channels. The Committee believes that the Ministry should report the results of its investigation and any resultant action in each such instance, to the College of Physicians and Surgeons for review. In the event that the Board judged it necessary, it would proceed to investigate the complaints further as under (1) - (A complaint by an inmate or student or relative regarding medical services lodged through Ministry channels.) The Board appointed by the College should report to the Minister, to the complainant and to the person outside the Ministry who received the initial complaint.

With the passage of time and the development of the Health Disciplines Act, it is anticipated that additional legislation will govern the specialized health services of clinical psychologists, social workers (medical and psychiatric), the nurse practitioner the physician-assistant and physician-associate, et al. Allied health professionals and the individuals they treat need protection under the law.

i) Planned program budgeting

At the present time no responsible professional, such as the Executive Director of Health Services, Chief Medical Officer or Director of Health Services of an institution, contributes to planned program budgeting for health services in keeping with a Ministry policy. The result is undesirable variability from institution to institution of the development of the facilities, equipment and staff

for health services to adult inmates; this is less in evidence for health services to wards in training schools.

The redevelopment of the system of health care delivery is dependent upon Ministry policy requiring the Executive Director of Health Services to accept responsibility for the executive direction of the system of health care delivery. So that Ministry policy can be implemented successfully, the Committee recommends that the Executive Director of Health Services be responsible for the development and operation, in keeping with Ministry policy, of the planned program budget for the Ministry system of health care delivery.

Included in the budget for delivery of health care, i.e. health services, should be:

(1) Personnel -

- (i) Salaries, sessional indemnities and fees-for-service, paid to physicians (including psychiatrists, radiologists, physiatrists and all other specialists) dentists and nurses;
- (ii) Salaries, sessional indemnities and fees to allied health professionals (e.g. specialized social workers, psychologists, speech therapists, health records librarians);
- (iii) Salaries and sessional indemnities to allied health and auxiliary health personnel (e.g. dental hygienists, radiographers, electroencephalographic technologists, laboratory technicians, registered nursing assistants);
- (iv) Personnel - non-health (e.g. secretaries, stenographers).

(2) Health services special equipment.

(3) Health services supplies, consumable.

j) Remuneration of health staff

Ministry consultants must be remunerated taking into full consideration -

- (i) that consultants of outstanding reputation are indispensable to the ongoing redevelopment and renewal of the Ministry health care services;
- (ii) that the appointment is for a defined term;
- (iii) that professional isolation still remains a feature of working in correctional institutions;
- (iv) that the appointment cannot include fringe benefits as the consultants are not part-time civil servants;
- (v) that if the consultant is engaged in fee-for-service private civilian practice his office overhead must be maintained.

Therefore, it is recommended that consultants should be paid at the rate of the next taxable income represented by the upper level of the third quartile of their professional group in Ontario according to the latest available taxation statistics projected to the current year.

Payment of medical officers (including general practitioners, and pediatricians)

General physicians should be paid on a sessional basis reckoning the working week as eleven half-days of three-hour sessions. The number of half-day sessions per week for which the physician is retained and paid should be settled annually in the course of developing the health services budget. In the regular way the half-day sessions provided for in the budget should include accepting, on an equitable basis, responsibility for emergency calls. This plan will require

modification in some very small jails, small training centres or camps where it will be necessary to develop special combinations of a retainer and "fee-for-service". Special thought will be needed to ensure that these few special arrangements do not result in a scale of payment which is out of line with the results of the general policy of payment on a sessional basis.

In any case, mandatory provision should be made for retirement, even of part-time medical officers and consultants.\*

Both the number of sessions per week for which a physician is retained by the Ministry, and special arrangements in small establishments, require the recommendation of the Executive Director of Health Services and the concurrence of the superintendent of the Ministry institution. In arriving at a scale of remuneration for general physician or medical officer, the Ministry must recognize that physicians working in adult correctional institutions are more isolated professionally, both geographically and because of the institutional setting, than their colleagues "on the street" (even a far northern street); that they must deal with inmates who commonly attempt to manipulate physicians in an attempt to obtain drugs or to do a "stall" to avoid work; that from time to time physicians must put up with abuse from adult inmates; that physicians employed by the Ministry commonly feel they are viewed as "second class professional citizens" by their civilian medical colleagues; that the recruitment of first class physicians is the primary requirement of redevelopment and ongoing improvement of Ministry health services

\*Note: The age distributions of health personnel are shown in Appendix 10.



for children/wards and for adult inmates.

With full consideration of the existing need for physicians in the Ministry and the factors recorded above, the Committee recommends that the Ministry pay a part-time general practitioner or family physician starting to work for the Ministry on the basis of eleven-elevenths ( $11/11$ ths) representing the mean (average) net taxable income of their professional group in Ontario. Remuneration for one half-day session per week throughout the year in the service of the Ministry would equal one-eleventh ( $1/11$ th) of the average income for their group in Ontario according to the latest available taxation statistics projected to the current year. Remuneration of medical officers should be reviewed annually. Increase in the rate of remuneration should relate to meritorious service, and to increase in the average income of physicians in his group in Ontario.

The Committee has supported the role of the part-time physician, generally employed not less than three half-days, and not more than six half-days per week, as the most widely appropriate one. No appointments exist in other departments of the Government of Ontario for part-time physicians who are not regular civil servants and which present comparable complex and difficult circumstances of professional employment.

As a move to upgrade the professional calibre of medical officer, a differential should be established for those serving as medical officers in adult institutions or training schools who hold the Certificate and are members in good standing of the College of

General Practice. A further differential could be established for those holding the Certificate in Medicine or Pediatrics and who are Fellows of the Royal College of Physicians and Surgeons of Canada.

Payment of full-time medical officers

A medical officer, judged competent by the Ministry to deal with the clinical complexities of "correctional medicine" under the circumstances of isolation, etc., must be paid a salary competitive with the return from private practice. Proper civil service classification for Ministry appointments in "correctional medicine" must be established. A minimum starting salary of the order of \$30,000 per annum is necessary to attract physicians.

Psychiatrists and other medical specialists

The same principles put forward for general practitioners, general physicians and pediatricians serving as medical officers on a sessional basis should apply to specialist-consultants regularly serving on a sessional basis in attending training school, jail or adult correctional institution.

Payment for medical services on a fee-for-service basis within the Ministry may be made necessary because of shortages of professional personnel, geography, or the size of the institution. Professional services will be provided also outside Ministry institutions on a fee-for-service basis.

In both situations, the recommendation is that the fee-for-service tariff for medical services which is accepted by O.H.I.P.

should be utilized by the Ministry with appropriate allowance for travel time.

Should difficulties develop between Ministry and physician over payment for services on the fee-for-service system, the plan established by O.H.I.P. and the College of Physicians and Surgeons of Ontario should be utilized by the Ministry.

#### Payment for dental services

In adult institutions and training schools dentists should serve either as full-time employees of the Ministry or on a part-time sessional basis. Under certain circumstances, such as an emergency in a Ministry facility or for work done outside the Ministry, the dentist would be paid on a fee-for-service basis. Whatever the method, if adequate dentistry of good quality is to be provided in the Ministry, dentists must earn incomes at least equivalent to the average income derived from civilian practice for the reasons alluded to in respect of physicians.

#### Payment of nurse practitioners: New classification

The Committee recommends that a civil service classification be developed for nurse practitioners. In pragmatic terms the nurse practitioner should be paid about \$2,000 a year more as a starting salary than the most highly rated clinical nurse starting as nurse in charge of the health centre in a training school or an adult correctional institution.

Classification as a nurse practitioner should not be confined

to graduates of university schools of nursing who, other things being equal, should be advantaged. Experience and ongoing education should enable selected Ministry nurses and others who are hospital graduates to establish their competence and serve as nurse practitioners.

## 2. Health services outside Headquarters

### a) Jails and regional detention centres

The maintenance of the best possible health services in jails and regional detention centres requires special consideration, broadly speaking of -

- (i) the small jails in small communities;
- (ii) medium jails;
- (iii) regional detention centres and large jails;
- (iv) the Toronto (Don) Jail.

Identification of the Toronto (Don) Jail and its problems is inescapable for it is unique by virtue of its size, age and inferior and obsolete structure. Toronto, a city of about two million, a seaport and major air terminal, the destination of a very large number of immigrants to Canada, is entirely dependent upon the services of the Don Jail. It receives approximately one-third of all admissions to jails in Ontario.

Special consideration of health care in jails is needed because of the annual inflow and egress of some 80,000 individuals annually. The total Ontario jail population approximates 1,700 persons at any

one time. The average duration of stay is about 9.5 days; under the Bail Reform Act the accused may be in jail for only a few hours and, if "innocent", never return. Alternatively, because of multiple remands, for reasons of security, or for special treatment purposes, inmates may be held in a jail for many months.

#### Screening and supervision

Prompt, effective medical screening and assessment of the health status of the mass of individuals admitted to jails must be a primary requirement. It includes search for parasitic infection, tuberculosis, syphilis, gonorrhoea, infectious hepatitis, infectious mononucleosis, alcoholism and drugs toxicity and their complications. Medical/nursing supervision in support of the correctional staff is essential to minimize the morbidity and mortality from acute medical, surgical, psychiatric and chemical emergencies manifest in the hours or days following admission, such as haemorrhage from a peptic ulcer; intra-cranial haemorrhage; depression and suicide, etc.

#### Variability of inmate population and health services in jails

In all but the smallest jails examples occur of the peak maximum inmate population substantially exceeding the rated maximum capacity; e.g. 836/753; 163/142; 148/57; 112/68; 59/34; 46/24. (See Table 3.) The Committee has visited these six jails. The medical staff (nursing staff exists in only two of these jails) is not provided to handle these inmate population peaks; particularly is



this the case in the ratios 148/57 and 59/34. This situation reflects the substantial number of existing ancient small and medium-sized jails and the Toronto (Don) Jail. These are in process of being replaced by regional detention centres.

The Committee recommends that elimination of overcrowding in jails should be given a high priority by the Ministry on grounds of health.

The damaging effect on mental and emotional health of cells characterized by various combinations of bad ventilation, lack of plumbing in cells, double occupancy, cells of grossly inadequate size and poor lighting, and of overcrowding, or all of them, in these ancient jails seems obvious. It is often reinforced by minimal plumbing facilities (showers, basins and latrines), in the cell corridor, peeling plaster and general dismal grubbiness, notwithstanding the evident efforts made by staff in support of cleanliness and hygiene.

Under these circumstances the need is increased for fully adequate health services.

#### Small jails in small towns

The services of a physician are difficult to obtain. There is insufficient work for a full-time nurse or nurse practitioner.

The proposal is made that the part-time services should be retained of an experienced nurse or nurse practitioner who commands the trust and confidence of the medical officer.

The terms of appointment would have to be established for

each situation by the Director of Nursing, with the concurrence of the local superintendent and the medical officer and the approval of the Executive Director of Health Services. The Committee proposes that the nurse should undertake to devote the equivalent of three half-day sessions for treatment services, assessment of health status of admissions and assessment of fitness for transfer; also included should be emergency calls, the administration of the health centre and the health education of the correctional staff. In the event that she was unavailable, an alternate would have to be available, agreeable to the medical officer, superintendent and Director of Nursing. Professional nursing services requiring more than the equivalent of three half-days would be on an additional equivalent half-day (3 hours) basis agreed upon by superintendent, medical officer, nurse and Director of Nursing. Twenty-four hour coverage by nurse and physician, or physician, is needed in small jails as well as medium and large jails.

#### Medium jails

The Committee proposes that initially the services of a nurse or nurse practitioner should be provided and as soon as possible, on the basis of five half-day sessions per week (experience may indicate that fewer or additional sessions are needed); three sessions should be firm scheduled commitments, one of which should be devoted to administration and health education of correctional staff, as well as health care. The equivalent of the remaining two half-days

should cover emergencies, initial assessments of admissions and of inmates prior to transfer as necessary. The ready availability at all times of nurse and physician, or physician, requires that alternates would have to be provided by an officially established means which will vary from community to community for nurse as well as physician. No reduction in the commitment of the medical officer is indicated until operational studies following the establishment of the nurse practitioner have been completed. In some jails an increase in time should be sought from the medical officer.

#### Larger jails and regional detention centres

It is proposed that the services of a nurse practitioner and nurse or registered nursing assistant should be provided daily on the day and evening shifts. No reduction of the commitment of the medical officer should be undertaken without operational research studies and, in some jails, increased time will be needed. Staffing arrangements must be such that the nurse can be called without hesitation or embarrassment for emergencies by the superintendent or his staff during the night.

In the regional detention centres there are infirmary beds. In the larger jails minor medical illness and seriously ill patients with psychiatric disorders and with alcoholism have to be treated in the cells - so-called medical units. This becomes particularly burdensome where the jail is also a lock-up.

#### Toronto (Don) Jail

The Toronto Jail is responsible for about one-third of the total inmate days of the jails of Ontario (259,256) in 1971; it serves

as the maximum security wing of the Vanier Centre for Women and as their punishment cells; it is used as a centre to transfer inmates who are security risks from other jails and correctional institutions, often en route to Millbrook; the inmate population (average 711) in 1971 is largely derived from Metropolitan Toronto and the health problems reflect the diversity and size of the population; the jail is recognized as a psychiatric centre to which judges remand prisoners for psychiatric assessment.

The obsolete structure of the Toronto Jail has been well established. The following health services facilities are obsolete and are physically scattered:

- (i) The psychiatric cell block and facilities;
- (ii) The offices for medical officer and the dispensary and nurses' office for male patients;
- (iii) The medical and nursing facilities for female inmates;
- (iv) The psychologist's office and the social worker's office.

Communication is difficult and inescapably the health services are fragmented.

What is remarkable is that medical disasters are almost completely prevented under such trying circumstances for inmates, doctors and nurses, and correctional staff.

The complexities and enormous difficulties of operating the Don Jail have been put forward. The role and scope of the nurse/nurse practitioner increases correspondingly in significance.

A full-time nurse practitioner service is needed in this jail

as a new and major component of the multidisciplinary team which already includes nursing. One nursing service is in being for the psychiatric unit (10-cell block); another nursing unit looks after the women's division and the "hospital" or medical examination area. There is need for integration of the nursing services and for education and upgrading of the nursing staff.

There is no sick bay or infirmary containing beds and male inmates are treated in their cells or in a special cell block.

The fragmentation and isolation of general medicine from psychiatry is matched by the fragmentation of the nursing service between general medicine and psychiatry.

The need is conspicuous for unifying professional leadership in nursing in the Don Jail; the proposals and recommendations for leadership are well put forward in the Nursing Consultant's report (Page 29, Appendix A) and are applicable to the Toronto (Don) Jail.

The Committee recommends that immediate development of a new health centre facility (including psychiatric facilities) for the Toronto Jail should take place. It should be based on the concept of comprehensive multidisciplinary health services. It should include general medical infirmary beds. Much improved facilities for psychiatric consulting services for inmates are needed. Until medium security regional psychiatric unit hospital facilities are available, a group of beds for this type of psychiatric patient is needed in the Toronto (Don) Jail and should be adjoining the general medical infirmary. A maximum security psychiatric unit will



continue to be needed.

The Committee recommends that the existing psychiatric unit be replaced without delay. It is an obsolete, archaic cell-block psychiatric facility. Even with its devoted medical, psychiatric, and nursing staff, it is an unsatisfactory and inappropriate psychiatric facility in which to assess patient/inmates' mental and emotional health before trial and/or before sentence.

The psychiatric staff serving the inmates of the Don Jail requires major expansion on the basis of one half-day psychiatrist session per week per 40-bed capacity, the standard endorsed by Professor Chalke and the Committee. Available psychiatric services are diluted by referrals of cases from the Department of Justice for psychiatric opinion, by having to supply relief psychiatric consulting service to the Guelph Neuro-Psychiatric Clinic, and by the transfer of disturbed women from the Vanier.

It is further recommended that new health centre and psychiatric facilities should not be postponed for the years needed to plan and build new regional detention centres in Toronto.

#### Regional detention centres

These new institutions constitute a great advance. They permit classification and segregation of inmates. They make possible work programs for economic gain or for training outside the institution for selected cases and consequent improvement in mental health. The centres provide the Ministry's rehabilitation program with a new opportunity for a group of individuals to

rehabilitate themselves.

This improved program, of great potential value for prisoners, requires an equal advance in providing: (a) comprehensive multidisciplinary health services, and (b) Health Status Reports.

Visits to the Regional Detention Centres at Napanee and Ottawa lead to the conclusions that the health services branch of the Ministry should be involved immediately in -

- (i) plans for modification of the existing health facilities in the health centre, for both medicine (including psychiatry) and dentistry;
- (ii) plans for medical and dental facilities in the health centre of the regional detention centres about to be built.

Included in the unsolved problems of the health centre are -

- (i) inadequate provision for nurse practitioner, physician medical officer, and psychiatrist to see and examine patient/inmates of either sex at the same time and with privacy;
- (ii) inadequate dental facilities for a modern, efficient, two-chair operatory and for the proper role of upgraded dental hygienist, and dental assistant;
- (iii) arrangements facilitating involvement of specialized social worker and clinical psychologist in collaborative comprehensive health care based on the health centres.

The minimum health services staff initially should be:

- (i) Medical officer, for five half-day sessions per week which would include responsibility for emergency calls, the responsibility for the administration of the health centre, and a commitment to advance the health education of the correctional staff. (Fewer sessions might suffice at Napanee.)

- (ii) Nurse practitioner, one full-time as chief of nursing service.
- (iii) Nursing (R.N.) service including the nurse practitioner should be provided on the day and evening shifts, seven days a week. Nurses should not act as cleaners, filing clerks or assistant for the dentist. In the event further expansion of the nursing service is contemplated, the employment of registered nursing assistants should be considered.
- (iv) Psychiatrist - Three half-day sessions per week including educational contribution to the medical, nursing, and correctional staff.
- (v) Allied health professions - The extent of the need for the specialized services of social worker (medical or psychiatric) or psychometrist and psychologist in the health services is unclear; the new plan for classification and segregation in regional detention centres will create new needs. On the basis of presently available information no firm recommendation is being made. The psychiatrist's services should be matched by the services of psychometrist and psychologist. The specialized social worker's contributions relate to the general medical and psychiatric service.

The proposal is made that initially a half-time psychologist or psychometrist and half-time social worker should be employed in Ottawa and Napanee. The operation and staffing of the health services in Ottawa and Napanee regional detention centres should be regarded as test model pilot projects. Operational research should be planned prospectively and provide for systematic evaluation of all aspects of the health services including morbidity, mortality and cost benefits.

b) Adult institutions (excluding jails)

Variability of the health services staff-to-inmate ratio, of the availability of health services and of the quality of health care, are the features of health care in male correctional centres. The health services range from effective care to a quality of health services which is unacceptable. (See Pages 52 to 67.) However, general medical services are effective in the majority of correctional centres.

The quality and range of health services available and actually provided, including medical, psychiatric, dental, nursing, social and psychology services, to the inmates of correctional centres vary remarkably from institution to institution.

In three correctional centres, to the personal observation of the Committee and the psychiatric consultant, psychiatric consulting and treatment services are effectively non-existent and, in two of these, psychologists' services are also effectively lacking.

Psychologists are in short supply. Psychometrists, obliged by their conscience to do what they can to help, write not only psychological reports but observations on psychiatrically ill patients.

In one major correctional centre examination following admission and patient examination at sick parade are token in character and are of unacceptable quality. In another adult centre admission examinations are effectively lacking.

In some centres the nursing staff consists of one nurse only,

which is inadequate. Neither comprehensive nursing care nor a contribution to the rehabilitation program is possible.

Ministry policy is needed establishing the minimum numbers of physicians, psychiatrists, dentists, nurses and psychologists, psychometrists and other health personnel for correctional centres on an institutional and regional and Ministry basis. On an institutional basis because different institutions have remarkably different needs. Psychiatric problems of inmates at Millbrook outweigh those of inmates at Brampton Adult Training Centre. On a regional basis, because the Brampton Jail and Adult Training Centre and Vanier Centre for Women should be able to obtain increased cost benefits and improved services from utilizing doctors and nurses, et al., on a shared regional basis. On a Ministry basis because of the need for Ministry-wide consultants and for Ministry-wide policy to guide the system of health care delivery.

In a general way the ratio between primary health care professionals and allied health professionals on the one hand to clients on the other, influences the quantity and quality of available health services.

Role of "professional" (physician, nurse, et al.)  
in adult correctional centres

Of importance to doctors, nurses, psychologists and social workers is the maintenance of their professional relationship to inmate patients and their freedom from professional direction, real or implied, by superintendents and administrators.



The transfer from a "professional" role to that of a member of the superintendent's or Headquarter's administrative staff removes the individual immediately from his erstwhile professional responsibilities and status. Lack of understanding of this role change has been observed in social workers and psychologists engaged in general administration.

Medical officer: Adult correctional centre

The Committee's observations indicate that a minimum of three half-day sessions plus provision for emergency calls should be contracted for a part-time general physician serving an adult correctional centre so that a physician can become interested and involved in the total health services and Ministry rehabilitation program.

The full-time nurse practitioner should assume a significant portion of the professional work now carried out by the physician. No reduction in the time required of the medical officer should be contemplated save following operational studies.

The Committee believes that for a physician working in an adult correctional centre to maintain his professional standards and avoid taking on a custodial role, he must maintain his practice and professional associations outside the adult correctional centre. The Ministry should therefore limit the maximum commitment of a physician serving an adult correctional centre (jail or regional detention centre) to a maximum of six half-day sessions per week and to the necessary emergency services.

The Committee also recognizes that individual physicians may wish to enter the service of the Ministry as full-time civil servants. Their objective over the longer term would be to assume senior administrative responsibility as a member of the correctional staff or the health services staff, or to take part in the Ministry treatment and rehabilitation services other than health. Social workers and psychologists have already embarked on this course.

Establishment of guidelines for health services  
personnel: Adult correctional centres

Consideration of the needs for numbers of any one profession in a correctional centre should be considered in relation to -

- (i) the multidisciplinary team as a whole;
- (ii) the progressive introduction of the nurse practitioner;
- (iii) the multiphasic screening of primary incarcerated and the development of an efficient Ministry health records system;
- (iv) the special Ministry function of each institution or centre and its special need for health services.

The conclusions of the Committee are that major efforts should be made to remedy certain existing deficiencies which vary from institution to institution, at the same time Ministry policy concerning minimum numbers of health services staff is being developed.

Auxiliary personnel

Expanded clerical and secretarial assistance should be provided in health centres of adult correctional institutions (non-inmate).

The quantity of paper work involved in admissions, sick parades, hospital referrals, transfers and discharges, impairs professional services to patient/inmates.

#### Adult training centres

A general recommendation is made to the effect that each adult training centre, e.g. Rideau, Brampton, Burtch, Thunder Bay and Monteith, should have available the services of a nurse practitioner by sessional employment and/or regular visits and emergency visits, from one who is serving a cluster of institutions and centres.

#### c) Training schools

The services provided by general practitioners and the nursing service were decent and effective in every training school visited. The limitations have been imposed by fragmentation and separation of general medicine, psychiatry, social work, psychology and psychometry. The staff and general health care in training schools have a more consistent relationship to student numbers than is the case in adult correctional centres.

Psychiatric consulting services are in short supply all year in some schools and seasonably in others and should be expanded.

Specialized adolescent obstetrical and gynaecological consulting services should be developed, particularly with regard to the problems of abortion. Information from several sources makes it clear that students/wards, both boys and girls, are very often

ignorant of all but the most elementary facts concerning sexuality, venereal disease, the physiology of reproduction, and contraception. It is recommended that medical officers and nurse practitioners should undertake an ongoing program of education in these areas as an individual or small group program; these programs should not be part of the required educational program which is the responsibility of the educational staff. Additional educational expertise and resources concerning these problems should be readily available to doctors and nurses for use with students/wards.

Clinical, electroencephalographic, neurologic, psychiatric and metabolic biochemical assessments should be expanded for first offenders especially. This can be achieved best through affiliation of Ministry reception and assessment centres with universities and their health sciences complexes. The humanitarian concept that a boy or girl as a minor should not acquire a criminal record must not be damaged; at the same time, a means must be found to ensure that as an adult the health services data accumulated when he is a ward will be readily available to courts and federal correctional institutions, civilian health agencies and to professional personnel caring for his health. In some instances Ministry adult correctional institutions currently obtain the complete general file and health record of men and women who, as students, have been in training schools. Ministry training school records, including health records, are not readily available presumably because of the lack of a modern central Ministry

records system. The Committee has been told that there is nothing in the Juvenile Delinquents' Act which requires that records be withheld in the event of subsequent conviction as an adult. The health record may be equally important for his medical care as an adult.

The effectiveness of the various health services treatment programs in training schools should be researched employing some form of evaluative experimental design. Individual psychotherapy, group therapy, therapeutic milieu/community, transactional analysis, reality therapy, all require evaluation whether administered and operated by physician, psychiatrist, nurse, social worker, psychologist, psychometrist or chaplain. Inescapably, all such research evaluating the effectiveness of treatment includes many requirements of which two are:

- (i) Comprehensive multidisciplinary health investigation and diagnosis before treatment.
- (ii) A follow-up for a period following graduation of students treated in training school, such as the period of parole and wardship, and early adult life.

A means must be found to ensure that the individual can be followed up as a ward and after he is 18 without destroying the humanitarian concept of providing the individual with a fresh start as an adult.

The Committee concludes that in the absence of such data, the multidisciplinary health management of succeeding generations of students in training schools will be based on impressions instead of firm data. Notwithstanding the existing dearth of results of



follow-up studies, current treatment must proceed using the best available situational judgments. In the choice of optimum current treatment methods, the health services professional staff should look to the Ministry Consultants, the Health Services Advisory Board and related university health services complexes, for constructive and helpful professional collaboration and development of professional Ministry policies.

Students are in the period of growth and development. Whether or not they have had a serious illness in training school or are epileptic or diabetic or the like, upon graduation and return to the community each boy or girl should be returned to the care of his own doctor or referred to a new family physician or to a clinic. This involves willingness to accept the patient. The physician or nurse at the training school must ensure that the results of the comprehensive health service investigation are promptly passed on to the responsible family physician. The Public Health nurse can play a significant liaison role in achieving continuity of medical care. The same principle applies to utilizing hospital clinics, to the Indian Medical Service, et al.

It is recommended that each student/ward should have continuing medical health care arranged prior to graduation.

#### Recidivism among students of training schools

The Committee in the course of interviewing inmates in jails and adult correctional centres encountered a number of ex-students of training schools. It has been said to the Committee that not

uncommonly it is better for a boy who might be regarded as either a case for a hospital or home for disturbed children, or a training school, to be sent to the latter. The Committee is quite uncertain about such a choice; it is impressed that real hazards related to future recidivism accompany a stay in a training school for many of the boys who are sent there, whatever the reason.

Multidisciplinary screening of primary  
admissions to training schools

The Committee places the highest priority on the most effective possible multiphasic multidisciplinary health screening for boys and girls committed to training schools for the first time.

The basic objective envisaged is to recognize the children in whom health disorders contribute to delinquency, to correct this underlying disorder and prevent, if possible, the need for a stay in a training school. Continuing research over the medium and long term should identify new medical and neuro-psychiatric as well as psychological and social components of delinquency.

d) Health centres, reception and assessment centres, clinics

Health centre - comprehensive health care in  
training schools and adult institutions

The Committee conceives the health centre (hospital, sick bay) of the jail, adult correctional centre or training school, much as the Hastings Committee\* envisages the (separate model) community health centre. The added responsibilities exist of contributing to the Ministry program for assisting the student or inmate to rehabilitate himself/herself and to the health education of correctional staff.

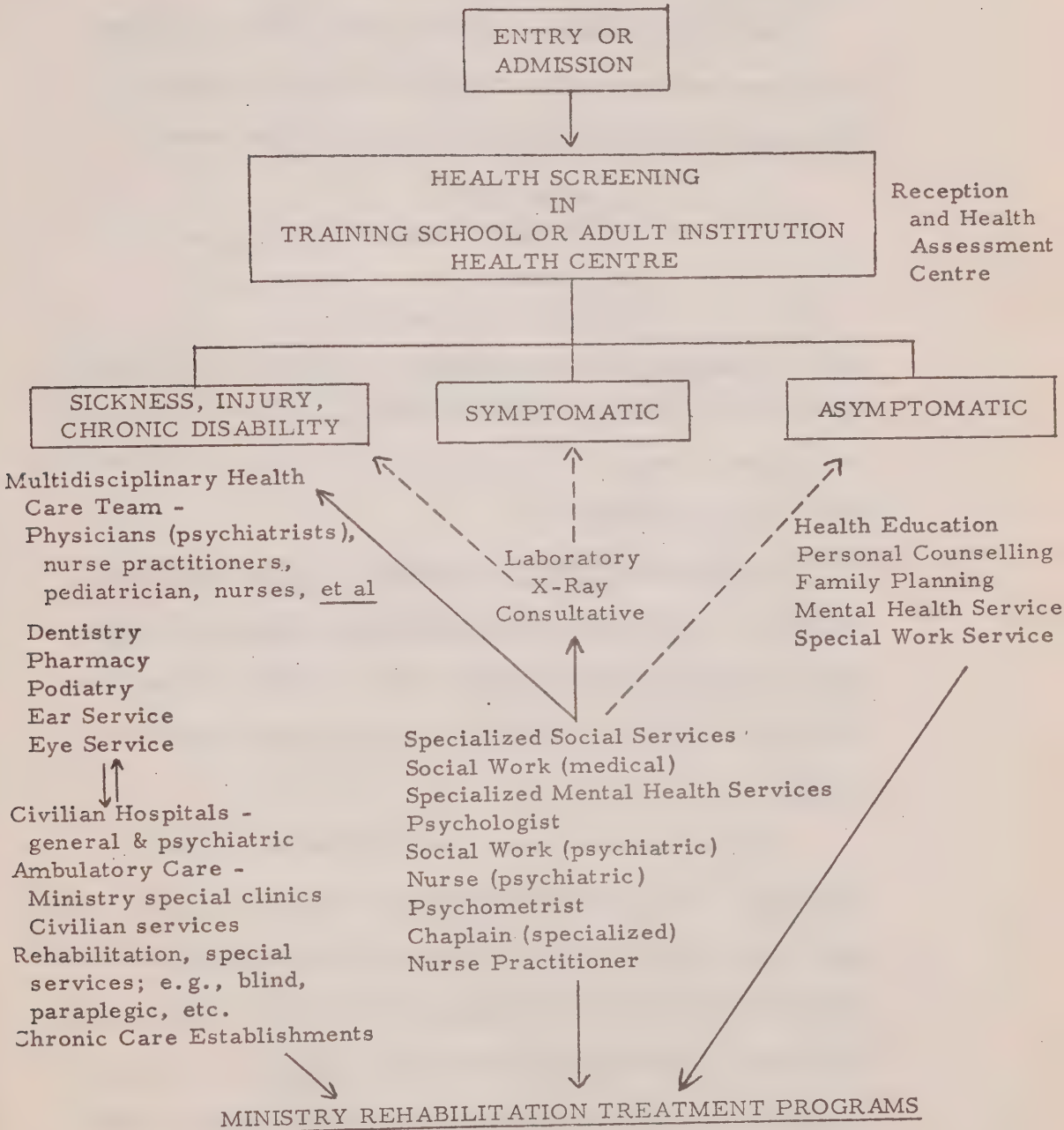
"...a facility, or intimately linked group of facilities, enabling individuals...to obtain initial and continuing health care of high quality...in an acceptable manner...through a team of health professionals and other personnel...working in an accessible setting...well managed setting...part of a responsive and accountable health services system...closely and effectively coordinated with the social and related services to help people, families, and communities deal with the many-sided problems of living..." (Hastings)

The diagram on Page 129 outlines the function of a Ministry health centre in which only the specialized social services and psychological services, e.g. clinical psychology and social work (psychiatric and medical) are included.

The Committee sees the social services centre as administratively separate but geographically close and in facilitative close collaboration. This arrangement is judged preferable to the "combined centre" (Hastings); i.e. the "single unit" centre providing

\*Report of the Community Health Centre Project to the Conference of Health Ministers (July 21, 1972) Dr. John E.F. Hastings, Chairman.

MINISTRY OF CORRECTIONAL SERVICES  
COMPREHENSIVE HEALTH SERVICE  
BY MULTIDISCIPLINARY TEAM



N.B. - 1. Health Status Report for student or adult inmate.  
2. Contribution to classification of individual.

health and all social services. The general social services are understood to include individual counselling, group counselling, family assistance, family legal aid, family counselling and vocational retraining.

Because the inmate or student, in fact, is almost always obliged to accept the health services provided by the Ministry, it is important to emphasize that health services must ensure -

- |                       |   |            |
|-----------------------|---|------------|
| (1) accessibility     | ) |            |
| (2) comprehensiveness | ) |            |
| (3) continuity        | ) | Boudreau * |
| (4) personalization   | ) |            |

and, (5) the highest possible professional quality of comprehensive health care, for "quality" is indispensable. This Committee supports the view that no one profession can provide a health service satisfying these five characteristics.

A collaborative effort by a team, at the minimum a doctor and nurse, is judged essential in the system of delivery of comprehensive health care in the Ministry. In fact, this is the team most commonly encountered. In some institutions it may include other professionals.

In some institutions other personnel are not available. Psychiatrist, social worker (medical or psychiatric) and psychologist may be employed but function in separate areas of school or correctional centre so that interdisciplinary collaboration is unplanned and ineffective. Fragmentation of professional effort occurs and the health service provided to the individual suffers. In some other



institutions, clinics and training schools, exemplary interdisciplinary collaboration has already evolved among the existing professional staff to the benefit of inmate and student/ward. It must be ensured that -

- (i) neither fragmentation of service or patient be allowed to occur to suit any health discipline.  
To this end it is recommended that all the health services provided within a Ministry institution for each inmate/student by nurse, nurse practitioner, psychologist, specialized social worker or medical consultant, should be in association with one responsible medical officer; he may be a general physician, psychiatrist, pediatrician, or internist;
- (ii) that general physicians, nurse practitioners, general duty, and psychiatric nurses, in adult institutions and training schools must be educated in the understanding of psychology and psychiatry for the benefit of student/wards and inmates of correctional institutions;
- (iii) all health services records should be readily available in one problem-oriented comprehensive health record. General physicians and nurse practitioners require knowledge of the conclusions drawn from social psychological and/or psychiatric investigation. The treatment by physicians and nurses of "functional" disorders, such as a spastic colon, tension headaches or complaints of "nerves", needs to be supported by this knowledge. Psychiatrists, psychologists, social workers, child health workers, et al., need understanding of existing physical disorders, such as temporal lobe epilepsy, brain tumors and migraine.

Many students and inmates have, over a period of years, been treated by the family physician and his nurse and have come to trust them. The training school or adult institution general physician or nurse may have from time to time an unparalleled opportunity to contribute in a positive fashion to the individual's efforts to rehabilitate himself/herself. The child or youth presenting himself with "physical" complaints to the nurse at bedtime may be taking the first small steps in search of help on the broad behavioural front;

- (iv) that general physicians, pediatricians and psychiatrists serving training schools, adult correctional institutions and regional detention centres, should be retained by the Ministry for sufficient time to allow them to contribute to the Ministry rehabilitation program as well as caring for the sick.

Reception and assessment centres (students/wards);  
Forensic Clinics of Juvenile Courts

The role of the Oakville Reception and Assessment Centre as a centre for comprehensive multiphasic (including psychiatric and specialized social and psychologic) health examination, is endorsed warmly. Resulting from this intensive individual health study should come a Health Status Report for each child/student contributing to appropriate classification. (See Pages 141-142)

The role of Oakville for students/wards from Central and Southern Ontario in relation to the Forensic Clinic of the Juvenile Court of Toronto requires consideration. The Committee believes this relationship deserves early and close study by the Executive Director of Health Services, Ministry Psychiatric Consultants and Ministry Health Advisory Board so they may advise the Deputy Minister. About 45% of Toronto students/wards have been investigated in the Forensic Clinic of the Juvenile Court.

The need exists for professional integration between the pre-trial or pre-sentence investigation and opinion developed by the Forensic Clinic and follow-up knowledge of the clinical course of the student in a training school and as an adult. Assessment of

the student, developing a Health Status Report for classification, health care and individual rehabilitation, all require the responsible initiative of the Ministry health services staff.

The Committee believes that the existing informal arrangement whereby Dr. Chamberlain, Director of the Forensic Clinic of the Juvenile Court of Toronto, serves as a part-time psychiatric consultant to Pine Ridge School, should serve as an example of the type of formal arrangements needed between the psychiatric service of the Forensic Clinics of Juvenile Courts and the Ministry.

Additional inter-Ministry arrangements require consideration. If pre-sentence or pre-trial psychiatric opinion is judged necessary, it should be part of a comprehensive multidisciplinary health screening. In the event that highly qualified professional staff, laboratory facilities and residential quarters are provided by the Forensic Clinics, they would closely resemble the health services envisaged at Oakville Reception and Assessment Centre.

The resources in professional manpower and the costs involved should preclude the duplication of comprehensive health assessment facilities at both the Forensic Clinics of Juvenile Courts and at Ministry reception and assessment centres. This broad problem of the provision of assessment facilities should be the subject of early inter-Ministry consultation and study.

Several possibilities deserve consideration:

- (i) The Ministry of Correctional Services could accept the responsibility for the operation of Forensic Clinics as part of the operation of Ministry reception and assessment centres. Integration under the auspices of the Ministry ought to facilitate and encourage follow-up studies of juveniles and so lead to improved overall treatment as well as improved health services. Hopefully, the number of juveniles requiring admission to training schools would be reduced.
- (ii) The health service of the Forensic Clinics of the Juvenile Courts could be of such comprehensive quality that their reports should serve as a basis for assessment and classification by the Ministry; all juveniles would have to be assessed by the Forensic Clinics to replace Ministry assessment centres.
- (iii) The professional staff of the Juvenile Courts' Forensic Clinics could be located and work with juveniles in Ministry assessment centres.

#### Oakville Reception and Assessment Centre

The Ministry should seek affiliation of the Oakville Centre with the University of Toronto and its schools, institutions and faculties; notably the Clarke Institute and its Forensic Clinic and the University affiliated Hospital for Sick Children.

The special knowledge and interest of the Hospital for Sick Children would add new and major diagnostic and treatment strength and research resources to the care of children/wards.

Liaison with the Forensic Clinic of the Juvenile Court of Toronto serving the Department of Justice and paid for by the Provincial Ministry of Health, will provide useful and important

psychological and psychiatric assistance to the Oakville Centre for children committed from the Toronto Juvenile Court.

The existing facilities in the Oakville Centre for comprehensive multiphasic health examination and initial treatment appear to be inadequate for these objectives. Reconsideration should be given to this problem by the Executive Director of Health Services and his advisors with a view to expansion of health facilities.

Other reception and assessment centres

For children in the Northwest and Northern regions of Ontario, regional reception and assessment centres should be established in relation to the development of university satellite health centres - in Thunder Bay to McMaster and in Sudbury to Queen's University.

The investigation of children in the Northeast and East of Ontario should relate to the development of Ministry regional reception and assessment centres associated with pediatric centres in Ottawa and Queen's Universities with their respective affiliated regional health services complexes. The extent to which liaison is developed between Oakville and Toronto Forensic Clinic of the Juvenile Court, will influence the evolution of Ministry reception and assessment elsewhere in Ontario in relation to Juvenile Courts' Forensic Clinics in other Ontario cities.

The Committee concludes that a unique and major opportunity exists to advance the health care and to contribute to the rehabilitation of children in the care of the Ministry.

The Committee at this stage favours the Ministry of Correctional



Services accepting responsibility for the operation of combined Ministry reception and assessment centres, and Forensic Clinics of Juvenile Courts, in affiliation with a university and its health sciences complex. The psychiatric staff and allied health professional staff of the Forensic Clinics could remain a separate unit within the Ministry reception and assessment centre; it could utilize the pediatric, neurologic and other medical staff and laboratory resources of the assessment centre. Of overriding importance is the requirement to develop with little delay Ministry regional reception and assessment centres, for at present neither Forensic Clinics nor reception and assessment centres exist other than Toronto and Oakville.

It is recommended that the principle of avoiding duplication should be accepted at inter-Ministry level. Successful application of the principle should be possible by one means or another in Ontario communities of differing size and community health resources.

Brampton Reception and Health Assessment Centre:  
Central Ontario Clinic - Adults

The proposal is put forward that one reception and assessment centre, which might be termed the Central Ontario Clinic, capable of a fully comprehensive medical, psychiatric, dental, specialized social and psychological examination should be developed. It should be aided by affiliation with one university and health sciences complex. Its location should facilitate such collaboration. If not

situated in a community with a university centre, it should be established at the new Brampton Centre. Considerable benefit to the inmates undergoing examination would accrue from the services of first-class consultants and involvement of resident physicians and resident psychiatrists as part of their post-graduate training. From interested residents should come new staff members.

It is recommended the Ministry should seek affiliation of the Central Ontario Clinic with the University of Toronto and its health sciences complex and affiliated hospitals. The development of affiliation should require the input of the Executive Director of Health Services and the Health Services Advisory Board.

The Central Ontario Clinic should serve:

- (i) All adult first incarcerates in Central and Southern Ontario, male and female, and all aged 16-18 committed to adult correctional centres.
- (ii) First incarcerates referred because of need for special health investigation from Ministry regional centres in Thunder Bay and Northern Ontario.
- (iii) First incarcerates destined for Millbrook should receive full investigation at the Central Ontario Clinic.
- (iv) Following evaluation of a trial period of operation and of clinical results, consideration should be given to receiving certain recidivists for assessment. These could be individuals in Central and Southern Ontario who have been assessed neither at the Central Ontario Clinic nor a Ministry regional health centre.

It may be estimated\* that the annual admissions to the Central Ontario Clinic will be about 2,342 first incarcerates, 18 years of age and older, and an additional 682 16-17 year-olds, for a total of about 250 per month. A capacity of 100 beds should serve this monthly intake with an anticipated maximum stay of about 14 days. This should also give enough margin to handle first incarcerates from Ministry regional centres in Northern Ontario needing special health investigation. If the new 200-bed Brampton Centre should be used for this Central Ontario Clinic, then the other 100 beds at the Brampton Centre could be allocated as follows:

- (i) 70 beds for sex offenders and alcoholics and other drug users now handled at the Alex G. Brown Memorial Clinic, and
- (ii) 30 beds for a special therapeutic regimen for drug abusers (including alcohol) differing from that of the A.G. Brown Clinic and under separate professional direction.

e) Regional health centres and regional consultants

To complement the Central Ontario Clinic there needs to be developed Ministry regional health centres to provide corresponding services in areas some distance from the central region.

On a regional basis, the corresponding Ministry population consisting of all male first incarcerates, and those aged 16-18, should be served by Ministry regional health centres. At Ottawa the regional health centre should be based on the Ottawa-Carleton

\*On the basis of data provided by Dr. James J. Hug, Program Analysis Coordinator, September 15, 1972.

Regional Detention Centre and should be affiliated with the University of Ottawa and its health sciences complex. The population for the regional health centre should be cleared through the Ottawa-Carleton Regional Detention Centre.

At Thunder Bay, the Ministry regional health centre, based on the Thunder Bay Jail, should relate to the McMaster satellite health centre; at Sudbury the Ministry regional health centre should relate to the developing Queen's satellite health centre.

To serve Eastern Ontario a regional health centre should be affiliated with and relate to Queen's health sciences complex. The regional health centre should be based on Quinte Regional Detention Centre.

The Ministry, through the Executive Director of Health Services, should develop appropriate local arrangements for regional Ministry health centres with the University of Ottawa and its health sciences complex for Ottawa with Queen's for Eastern Ontario; for Sudbury with the developing Queen's satellite health centre; and with McMaster satellite health centre for Thunder Bay Ministry regional health centre.\*

Regional detention centres: Ministry  
regional health centres

Special consideration must be given to staff and facilities of regional detention centres on which are based the proposed Ministry regional health centres for first incarcerates and all those aged 16-18.

It is recommended that affiliation with university and health

\*See also Page 99.

sciences complex, or satellite health centre should be sought. Such functions for regional detention centres are envisaged at Napanee and Ottawa.

Regional consultants - medicine, dentistry,  
nursing and allied health professions

By "regional consultant" is meant the professional serving Ministry institutions in an area corresponding to a region of the Ministry of Health. Regional consultants would be based on the regional health sciences complex or a satellite centre of the complex. They should be appointed upon the recommendation of the Executive Director of Health Services only after -

- (i) agreement regarding nomination or nominations has been reached by the appropriate Ministry consultant and university with its regional health sciences complex or satellite centre;
- (ii) the nomination has been approved by the Health Services Consultant Board.

The regional consultant must be differentiated from the physician, nurse, psychologist or dentist or social worker serving a geographical cluster or group of jails and correctional centres and training schools.

In the opinion of the Committee it is unlikely that many regional consultants will be needed in the near future if the role of the Ministry consultants is developed as envisaged.



### 3. Health screening, health records and information system

#### a) Comprehensive examination of first incarcerates - Health Status Reports

The Correctional Services and the health services for the population of Ontario have been developed and are being planned on a geographical, regional basis. The degree to which highly specialized services are created bears a relationship to the density and size of the population and probable utilization of the highly specialized services. To obtain the best possible health services and maximum cost benefits, the Ministry system of health care delivery should also be planned on a regional basis.

It seems of special importance to the Committee that first incarcerates should have fully comprehensive multidisciplinary examination. The correction of even a small number of health problems which would otherwise contribute to years of recidivism would be a great humanitarian gain and would represent worthwhile cost benefits.

Examples of the objectives of this examination are:

- (i) The identification of mental retardates and the planning of their long-term program as early as possible and with a minimum of custody in the Ministry.
- (ii) The identification of epileptics, suffering major attacks, minor attacks, petit mal and behavioural seizures (temporal lobe or psychomotor seizures).
- (iii) Neurologic disorders causing emotional and intellectual disorders.
- (iv) The identification of biochemical and metabolic disorders; e.g. diabetes, hyperthyroidism, myxedema, etc.

- (v) The identification of psychiatric conditions associated with or leading to episodic violence; e.g. schizophrenia, manic and hypomanic disorders.
- (vi) The identification of the sociopath or psychopath.
- (vii) Specialized social and psychological investigation of each case.
- (viii) Exclusion, positively, of syphilis and gonorrhoea.
- (ix) The recording of data permitting grading of physique, the function of arms and legs, of hearing, vision, dentition, mentation, and of emotional stability. This record should contribute substantially to better assessment and classification of the first incarcerates - A Health Status Report.
- (x) The creation of a comprehensive health service record which must accompany the inmate; the data must also be stored in a Central Data Bank, both for research purposes and for future clinical purposes.

For those inmates requiring classification from the jail by the Chief Bailiff, the health services in the jail should develop a Health Status Report. This should be a required document in the process of "classification" of all inmates by the Chief Bailiff. Limited as the resources for health assessment may be in jails, a medical report attempting this coverage would be a vast improvement over a total lack of such data. The jail medical officer is now often the only professional regularly serving the jail and for an adequate health status report it often would require the collaboration of other professionals. Only collaborative multidisciplinary effort - medical,

nursing, dental, psychological and social - can produce the best possible "Health Status Report".

In Central Ontario, for primary incarcerates and the group aged 16-18, this Health Status Report presently could be better developed at Guelph Correctional Centre than in jail or regional detention centre. As explained previously, it is recommended that a Central Ontario Clinic be established to take over this comprehensive health assessment function from Guelph.

There is a high incidence of recidivism and one individual may over a period be admitted to different jails and different adult institutions. The immediate availability of previous health services records, including training school, from Central Records at Ministry Headquarters, would result both in better health care and a better Health Status Report for the individual inmate.

b) Multiphasic health screening

Multiphasic health check-up examinations of apparently well inmates at the Central Ontario Clinic and regional health centres, including history taking, psychological testing and social studies, should be carried out extensively by technologists, nurses and nurse practitioners, psychometrists and social workers. After historical data, the results of medical, social, psychological and physical examination findings, laboratory data and the results of social and psychological investigation have been developed, the individual would be seen by the appropriate physicians including a psychiatrist, and dentist. The doctor has the valuable contribution of specialized social and psychological evaluation; social and psychological studies and Ministry (non-health) treatment and rehabilitation programs benefit from comprehensive health studies.

The professional back-up of such a multiphasic examination requires the consultants to support the program in a critical way, steadily deleting non-productive examinations and introducing new examinations reflecting advances in biological, psychological, psychiatric, social and medical and dental science.

Experience carrying out multiphasic screening has demonstrated the usefulness of the computer in any system of managing health data concerning the investigation and assessment of the individual patient and the storage of the data for later clinical or research use.

The recommendations are that:

(i) Multiphasic health screening should commence at the Central Ontario Clinic with a minimum of delay and should not be contingent upon the installation of an information system based on the computer.

(ii) A multidisciplinary evaluation should lead to a Health Status Report for the Classification Board.

c) Comprehensive health records system

Problem-oriented records

The importance of a unified comprehensive problem-oriented health record parallels the importance and reflects the collaborative efforts of the multidisciplinary team. The body of the health services record must be confidential to the health professionals. Only the conclusions and recommendations relevant to general Ministry treatment and management should be communicated, and in helpful and positive fashion, to the responsible Ministry staff. The inmate health record must be immediately available in the institution to health services staff. It must accompany the inmate upon transfer to other Ministry institutions. Upon discharge of the inmate or student/ward, the completed health record should be placed in a Central Records Storage and Data Processing Centre at Headquarters, indexed and classified, under the supervision of a Health Records Librarian\*. The significant data would be immediately available

\*The Committee supports the practice of those jails, correctional institutions and training schools maintaining a duplicate health record when an inmate or student is discharged or transferred to another Ministry institution or penitentiary. The existing policy and practice regarding disposition of records should continue until the Central Records Storage and Data Processing Services have established their reliability and efficiency.



for transmission by a modern communication system - telephone, telex, facsimile transmission, etc. - to any Ministry institution health service in jail, training school or adult centre. The health records should be available in the case of the student recidivist to Juvenile or Adult Court or Federal correctional health service. In the course of medical or psychiatric treatment in civilian life, the records of medical, psychiatric and dental services in the Ministry could be of major assistance to the physician and therefore to the patient.

Proper medico-legal precautions must follow established practice governing the release of confidential professional records.

Inmate/students must not have access to, handle, or file health records.

The Ministry Central Records Storage and Data Processing Services must be compatible and linked with the province-wide health information management system which has been studied extensively and is the subject of a report to the Minister of Health from the Ontario Council of Health.

Form 9801 is judged to be inadequate and to have negative value. The Committee believes it encourages a negative non-specific general statement regarding the health of an individual adult or student. The proposal is made that forms capable of computer processing and containing a series of questions similar to those used in a computer-taken history, in industrial medicine or in life insurance, should be developed for the Ministry to be

filled out by the inmate following admission under the supervision of the nurse, or by the nurse practitioner, or doctor, if the individual is incapable. Computer-taken medical histories have already proved their worth with cooperative patients in civilian life.

Depending on the degree of special education of the nurse practitioner and the willingness of the involved physician, the nurse practitioner may complete more or less of the physical examination, including visual and hearing acuity, and fill in the questionnaire.

Space would be needed for the observations of nurse practitioner and for the physician to develop a problem-oriented assessment.

Flexibility of the records system should ensure that among many other areas, additional space could be provided as needed for a problem-oriented record of specialized social and psychological studies. Records of the individual student or inmate in individual psychotherapy or in group therapy, must be kept by the responsible therapist as part of the comprehensive health record.

Dental records should constitute another separate section of the comprehensive health record.

Jails have their massive inflow and egress of inmates (about 80,000 per year) and generally short stay (average 9.5 days); they require a record system contributing to efficient and rapid screening. Alcoholism and drug dependence, mental and emotional disorders, and diseases or symptoms referable to the respiratory system, digestive system and injuries are the common medical problems.

Training schools' needs feature records regarding growth

and development - physical, emotional and intellectual. Mental disorders, anxiety neuroses and depressions, drug and alcohol dependence, skin eruptions, injuries and the common cold are recorded as major problems present on admission.

Adult correctional centres have special requirements for records related to drug dependence, alcoholism, skin eruptions, nervousness and debility, to the psychiatric results of incarceration, to self-inflicted wounds and injuries and to suicide and to sexual deviancy. In females, gynaecological problems are of special importance.

The continuing ready availability of the comprehensive record of the multidisciplinary investigation of students and adults developed during the first admission to training school or correctional institution is of particular importance in view of the incidence of recidivism.

The priorities of the Ministry of Health may delay the development of a new system for managing health information data, including electronic data processing of health care records and record linkage. In this event, the Ministry of Correctional Services should make an admirable model of reasonable size for development jointly by the Ministry of Health and Ministry of Correctional Services. The successful development of record linkage and a Ministry of Correctional Services Central Records System should facilitate the development by the Ministry of Health of a system of managing information concerning health, when "all health needs will be served by one comprehensive program" (An Implementation

Plan for the New Orientation and Structure of the Ministry of Health, August 22, 1972, Page 2).

Care is necessary to establish that in all Ministry health centres the examination and records system will be problem-oriented and developed in keeping with Ministry policy concerning management of health information. Effective record linkage and immediate availability of centrally stored records should be the goal. Even without functioning record linkage between institutions and Headquarters, the introduction of multiple-question forms and problem-oriented case records on a department-wide basis would be a most worthwhile beginning. The development of a Health Records Data Centre at Ministry Headquarters and the use of modern communication resources (the computer terminal, facsimile transmission, telephone or telex) should make a recidivist's earlier health record promptly available to the health centre in any jail, regional detention centre, correctional centre or training school. This should simplify, facilitate and improve health care.

The Committee recommends that expert investigation should be undertaken of the problem of managing health data produced in the Central Ontario Clinic and Ministry regional health centres and in the entire Ministry system of health care.

The group, which reported to the Ontario Council of Health and Ministry of Health, have given great thought to the development of a system for the management of information involved in the delivery of health care in Ontario.

## VII. SPECIAL AREAS FOR CONCERN

(Identification of health services problems  
and deficiencies with proposals for consideration)

The following recommendations are judged to be in keeping with the current and foreseeable needs of the Ministry health services and with the conclusions reached by the Committee. Development and necessary modification of these recommendations should be undertaken by the Executive Director of Health Services in keeping with the future development of the health services program for Ontario. The latter is in the midst of reorganization and change.

### 1. Effective use of health manpower

Physicians, nurses, dentists, allied health professionals and auxiliary personnel should work to the best advantage of students/wards and inmates. Their special knowledge and skills should be fully utilized. They should avoid tasks performed as well or better by individuals with less advanced training and education. The Committee has observed staff carrying out inappropriate duties. Adequate cleaning services and secretarial and stenographic assistance would make available more physician-nurse treatment services.

The role, scope, responsibilities and duties of auxiliary personnel and specialized allied health personnel in the Ministry must be redefined and numbers expanded.



a) Nurse/Nurse Practitioner

The Committee believes that "...it would be in the interest of the Ministry to upgrade and extend the functioning of nurses in its health services". (Smale) Additionally, emphasis must be placed on the importance of the need for "...the other necessary and supportive changes required in the (health care) system" (Smale) to achieve improvement of overall health care.

The nurse and the nurse practitioner must assume new responsibilities and play an expanded and uniquely important role in the delivery of health care by the multidisciplinary team, in jails, adult correctional centres and training schools. In fact, some nurses in the Ministry are already functioning as nurse practitioners because of their past experience and the support they receive from the physician or psychiatrist with whom they are collaborating, and from the correctional staff and teaching staff of the institution or school.

Role and functions of nurse practitioner

"The Nurse Practitioner is seen as a partner in a multidisciplinary team whose members share a common goal in providing health services which allow for continuity, accessibility, comprehensiveness and personalization in the care rendered to all." (Boudreau)\*

The care must be of the best possible quality. The Committee judges that under the circumstances of health care in the Ministry and under the existing Medical Act, the role of the suitably prepared nurse

\*Report of the Committee on Nurse Practitioners (April 27, 1972) Special Committee established by the Ministry of National Health and Welfare;  
Thomas J. Boudreau, Chairman.

practitioner is to serve as an extension of the physician in a way similar to that presently occurring in civilian clinic or community health centre.

"The Nurse Practitioner's role is viewed as an extension of the present nursing role, with unique skills in the care of the patient being developed and utilized more effectively, and the role in assisting the physician expanded through an increased delegation of certain tasks by physicians to suitably prepared nurses." (Boudreau)

The Committee judges the nurse practitioner with suitable training and experience should undertake the same functions in training schools and adult correctional institutions which the Boudreau Committee judged appropriate in civilian centres. The following is quoted from the Boudreau report and Paragraphs 1, 2, 3 and 7 are of special importance to the Ministry:

- " 1. The Nurse Practitioner can be the initial contact for people entering the health care system, that is, she can be the first health professional the individual sees.
2. As first contact, the Nurse Practitioner should be able to assess the individual's health status to determine the need for medical, nursing or other intervention.
3. The Nurse Practitioner should be able to initiate treatment for patients with commonly occurring health problems which lie within her scope of competence or to arrange for the referral of patients to the appropriate health professional (or agency) as needed.
4. The Nurse Practitioner should be able to counsel people of all age groups in relation to health matters.
5. The Nurse Practitioner should be able to teach individuals and families the specific knowledge and skills they require to maintain health and prevent illness, or to care for themselves or a family member in the event of illness and assist in their recovery and rehabilitation.

6. The Nurse Practitioner should be able to undertake the care of normal healthy women throughout the maternity cycle, including antepartum and postpartum supervision and counselling and, with additional specialization in midwifery, perform normal deliveries.
7. The Nurse Practitioner should be able to supervise the health care of well children.
8. The Nurse Practitioner should be able to supervise the health care of older people, except as they require medical intervention in the case of acute illness.
9. The Nurse Practitioner should be able to monitor patients with stabilized long-term or chronic illnesses and in consultation with the physician to adjust or modify treatment as indicated.
10. The Nurse Practitioner should be able to coordinate the health care of individuals and families through referral to appropriate health professionals and/or agencies as needed and follow-up of patients post-referral.
11. The Nurse Practitioner should be able to intervene in crisis situations, that is, to take action within her scope of competence or to refer the individual (or family) to the appropriate health professional or health agency for assistance."

In Ministry Health Services the development of the role and the scope of the qualified nurse practitioner will depend on the trust of her professional colleagues, especially medical colleague(s) and his (her) willingness to delegate responsibility; on the confidence and cooperative support of the superintendent and correctional staff; on her understanding and capacity to relate to students/wards, adult inmates and staff. The emphasis may be either on the nurse practitioner as nurse-physician assistant or nurse-physician associate. At this stage of the development of the nurse practitioner and, under the circumstances of the Ministry, the nurse practitioner must work

under the responsible supervision of the physician. With changes in the Medical Act, the nurse practitioner may be enabled to assume greater personal and legal responsibility for health care.

#### Nurse practitioner - psychiatry

The nurse practitioner involved in ambulatory care in training school and correctional centre has equal need with the general physician for special psychiatric education; understanding of the psychology and psychiatry of growth and development permits her to care better for students/wards; the attendance of the student/inmate with psychosomatic complaints at the nurses' sick parades may provide the first, and a major treatment opportunity; physical complaints are acceptable in the view of students. The psychology and psychiatry of general practice, and forensic psychiatry are especially applicable to the circumstances of the nurse practitioners' and the medical officers' sick parades.

For the interdisciplinary treatment team to function in the best interests of patients, a close-knit collaborative effort is needed between psychiatrist and general physician; and between general nurses and nurse practitioners, and psychiatric nurses.

The Committee recommends that the Ministry recognize and facilitate the undertaking by the nurse practitioner of a unique and responsible role in the system of delivery of health care in jails, adult centres and training schools. In this role the first three functions and seventh function (Boudreau) described above are of special significance; i.e. the initial professional contact involving

assessment of health status; the determination of need for medical, nursing or other intervention; the initiation of treatment or referral as may be appropriate; the supervision of the health care of well children.

The Committee recommends that the Ministry should take the initiative and provide financial support for the training of nurse practitioners on a return-of-service basis. Initially, nurses selected from the staff of the Ministry should be encouraged to qualify by additional training for this new role.

#### Role of the nurse practitioner in jails

In all jails and regional detention centres prompt initial health assessment must be carried out following admission, of ... "the individual's health status to determine the need for medical, nursing, or other intervention..." as Boudreau proposes for civilian health centres. The trained nurse practitioner should carry out this initial assessment with as close collaboration as the physician and nurse judge appropriate. The nurse practitioner should work under the supervision of the physician (Page 153-4). Supervision by the physician may consist of the active participation of the physician in initial assessment, consultation by telephone only, or by two-way closed circuit television, or a report the following day, or any combination of these methods.

The nurse practitioner, working under the responsible supervision of the physician, should also be established as competent



to determine if an inmate is fit for transfer or requires medical, nursing, or other intervention.

A number of individuals admitted to jails will stay only a matter of hours before being released on bail with no possibility for any health assessment by nurse practitioner or physician.

Whenever possible the nurse practitioner should serve clusters of adult institutions.

#### Role of nurse practitioner in correctional centre

In keeping with the general description of the nurse practitioner and her(his) role in health care, she must have a fundamental role in the health services of correctional centres and at the earliest possible date. In addition to the wide range of duties already described (Pages 151 to 154), she should be responsible to the chief medical officer for the administration of the health centre and its institutional employees.

The nurse practitioner should see inmates within three hours of admission; if she decides no medical, surgical or other intervention is needed, the inmate should be seen within a maximum period of three days by the physician. Needing medical treatment, the inmate would be seen as promptly as necessary by the physician in correctional centre or immediately referred to a civilian hospital.

The nurse practitioner should conduct sick parades and be established as competent to certify inmates as fit for transfer.

In the correctional centres, such as Millbrook, Burwash, Mimico and Guelph, because of their size, geographic situation and need to cope with special problems of behaviour, custody and psychiatric symptoms or illnesses, the Committee believes that nurse practitioners should be on duty on both the day and evening shifts seven days a week. A night nurse should be on immediate call at Burwash and Guelph. The availability of nurse practitioner and doctor, or doctor, is needed for night emergencies.

The ongoing medical, psychiatric, psychological and social education of nurse practitioners will be accomplished in part by the daily collaborative interdisciplinary activities. Formal continuing education is no less necessary, but the need for refresher courses and opportunity for self development or promotion should be recognized. In her turn, the nurse practitioner should contribute to the education of correctional staff in the health field.

b) Hospital officers (medical corpsmen, technicians, nursing orderlies)

In many jails, adult training centres, some adult correctional centres and work camps, circumstances do not warrant a full-time nursing service. The Committee recommends that in these settings "hospital officers" (medical corpsmen, technicians, nursing orderlies) should be provided who are correctional officers with special training regularly updated and recognized by means of added remuneration. Duties in the health centre or hospital would ordinarily become a

part or all of their work on their shift. The special training should include:

- (i) First aid, to the level of instructor.
- (ii) Technical maneuvers ordinarily carried out by technicians with some training such as collecting specimens of venous blood, of specimens of sputum, urine and stool.
- (iii) Taking and recording temperature, blood pressure, pulse, respiration and level of consciousness.
- (iv) Inspection of the male for communicable (including venereal) disease and parasites.
- (v) Counselling.
- (vi) Recognition of signs and symptoms suggesting mental illness and possibility of suicide.
- (vii) "Home" nursing measures.

The problem of having sufficient hospital officers to cope with shift rotation and holidays is recognized, but the numbers of hospital officers required should not be excessively costly. The beneficial impact of the decent treatment received by inmates from well chosen and appropriately trained hospital officers, backed and directed by the medical officer and/or nurse practitioner, should make a real contribution to overall Ministry treatment.

The redevelopment of the role and training and effective use of the "hospital officer" (orderly, corpsman, technician) is recommended.

## 2. Psychiatric services

### Psychiatric services in jails

Psychiatric consulting services vary remarkably from jail to jail; e.g. in one jail, serving also as a lock-up, psychiatric consultation and ongoing psychiatric support is readily available from psychiatrists engaged in private practice in the community. By contrast, a unit twenty-five miles from the nearest psychiatric hospital or general hospital psychiatric unit, has not yet been successful in obtaining the ongoing services of a psychiatrist on a major part-time basis. In one large jail the part-time services of a physician are not complemented by a psychiatrist. Expansion of psychiatric consulting services is needed in a number of jails.

Psychiatric treatment facilities in jails are inadequate and unsatisfactory for the acutely disturbed or depressed and suicidal patient. Upon the advice of the medical officer, inmates are transported to the emergency department of general hospitals for consultation and admitted for treatment of problems in the fields of general medicine or surgery with little or no difficulty. Beds are rarely available on short notice in the psychiatric units of general hospitals whether or not the superintendent of the jail will waive custodial measures or send correctional officers with the inmate. Similar difficulties are experienced in arranging admission to psychiatric hospitals unless the superintendent of the jail is able to waive custodial measures.

New and expanded medium security psychiatric hospital facilities should be made available to inmates of jails.

In one jail, patients recently discharged from psychiatric hospital have been admitted who, in the opinion of the jail physician, should be promptly transferred for re-admission to the psychiatric hospital. Hospital re-admission frequently has encountered difficulties to the disadvantage of the patient-inmate in the opinion of the jail physician.

#### Remand

In the course of visiting jails the Committee was told repeatedly by superintendents and other correctional officers, and by doctors and nurses, of the anxiety and depression generated in inmates by the long periods of uncertainty resulting from repeated remands. The Committee observed evidences of anxiety-depression during conversations with several inmates who had to face months in jail on remand. The enforced idleness, seemingly characteristic of jails, is an especially adverse influence for all inmates but particularly for long-stay inmates on remand. The Committee was also repeatedly advised that following conclusion of trial and almost regardless of the severity of sentence, the inmate's mental and emotional health improved.

In one jail, National Parole violators were reported as long-stay inmates who became seriously upset and depressed awaiting decision of the parole Board regarding their disposition.



Psychiatric services in correctional centres

A degree of variability in extent of psychiatric services exists from institution to institution which is comparable to that occurring in general medicine which must be regarded as unacceptable.

Millbrook Correctional Centre

The geographical situation of Millbrook contributes substantially to the extreme difficulty of recruiting health services personnel. Millbrook is effectively without psychiatric and psychological services.

It is recognized that the nature and function of this institution will likely change in the next few years. Pending change, it is proposed that the following health services personnel are needed and should be sought immediately:

Medical Officer - Five half-day sessions per  
week and for emergency calls

Nurse Practitioners on the day and evening shifts  
and for emergency calls

One Psychiatrist - Five half-day sessions per week

One Psychologist- (clinical) - five half-day sessions

Psychometrist - In relation to psychiatrist and  
psychologist

One Social Worker (medical or psychiatric) full-time

Dental services as judged necessary by the Dental  
Consultant Coordinator

A medical director should be appointed who may be either the physician or the psychiatrist.

The recommendation is put forward that affiliation should be sought with Queen's University and its health sciences complex, and

with a special relationship to the Kingston Psychiatric Hospital. Special emphasis is placed on the need for an effective relationship with the Department of Psychiatry and on the possibility of developing a medium security Regional Psychiatric Unit at the Kingston Psychiatric Hospital. Maximum security patients are transferred to Oak Ridges, Penetanguishene. A few patients are transferred to the Guelph Neuro-Psychiatric Clinic for diagnosis.

It should be pointed out that the physical facilities for health services at Millbrook are extensive. General medical and general surgical problems, save in highly specialized fields, are well managed in Peterborough.

It is recommended that to remedy the shortage of staff the Ministry cannot escape making significant financial commitments to support combined appointments in psychiatry at Queen's University, the Kingston Psychiatric Hospital and Millbrook.

#### Burwash Correctional Centre

The geographical isolation of this institution contributes in the same fashion as at Millbrook to staffing problems. While this institution too is likely to be radically changed by the Ministry, it is at present effectively without psychiatric or psychological services. Major efforts by the Executive Director of Health Services and the appropriate Administrator of Adult Institutions should be made to redevelop administrative and professional roles of the institution's staff.

A medical director is needed whose terms of reference will include the responsibility for the comprehensive multidisciplinary health services. Major efforts must be made to obtain psychiatric and psychologic assistance based on Sudbury. It appears that Sudbury will develop as a satellite health centre related to Queen's University. This development should expand the support-base available to the Ministry in Sudbury.

It is recommended that financial support from the Ministry must be provided to ensure the development of adequate psychiatric and psychologic services based on Sudbury which will serve Burwash.

#### Vanier Centre for Women

This institution is unique both because it is the only correctional institution for women in the Ministry and because it is making a major effort in the direction of the therapeutic milieu/community. Consultants and Committee were impressed with the commitment of the administration, of the specialized social services staff, of psychologists and psychiatrists and nursing staff. The time contracted for by the Ministry has not provided for involvement by the physician in the therapeutic community drive. Of equal or greater importance, it appeared that the physician was not expected to take responsibility for the health of the inmates under the sometimes considerable stress of group therapy. In fact, the senior nurse has been discharging effectively the role of nurse practitioner. She has participated in the weekly meetings discussing the welfare

of inmates under treatment. It seemed to be her responsibility to report to the medical officer.

The psychiatric service is of high quality but cannot accept responsibility for the health of all inmates under therapy.

The recommendation is made that clear lines of responsibility for the health of inmates should exist. Allied health professionals engaged in group therapy should work in association with a physician directly or through a nurse practitioner. Each inmate should be the identified responsibility of nurse practitioner and/or physician. This is conceived as a professional responsibility of the health services which cannot be accepted by a physician, nurse, social worker or psychologist employed in an administrative non-professional capacity.

The enthusiasm and devotion of the Vanier staff to the therapeutic milieu/community is noteworthy. Some individual inmates in this small institution who are ill-suited to intensive therapy have a hard time adjusting. Loss of self-control manifested by an attack (including hair pulling) on a fellow inmate or correctional officer leads to automatic transfer to the Don Jail. The Vanier Centre has had no administrative or treatment responsibility for women transferred to the Toronto (Don) Jail. In the interests of the mental and emotional health of disturbed inmates and minimizing of depression, detention in Vanier would be preferable to transfer to the Don Jail.

Two Indian women who had just been admitted were observed by the Committee. This led to discussions with Dr. Boothroyd, who was consultant psychiatrist to the Mercer for 14 years; with

the staff of the Vanier; with the superintendents of the Fort Frances, Kenora and Thunder Bay Jails.

General agreement existed in support of the view that transfer of Treaty Indian women from the Kenora and Thunder Bay districts, and from the North, to the Vanier Centre, usually accomplished little good and often had major potential for harm to the mental and emotional health of the individual. The therapeutic milieu/ community which may be appropriate and helpful for the non-Indian, has little relevance to the member of an Indian band from the area north of Sioux Lookout or from the bush outside Fort Frances.

#### Psychiatric hospital services for students/wards

The provision of psychiatric hospital services for children/wards ranging in age from 9-16 years, is a source of continuing difficulty and, particularly, for the disturbed adolescent. One cycle of difficulty starts with the child running away following transfer to psychiatric hospital; apprehension by the police; return to the training school. In other cases students/wards have exhibited behaviour too violent for the hospital to cope with and have been returned to the training school as behaviour problems. In the view of several training school superintendents, physicians and psychiatrists, the existing provincial shortage of psychiatric hospital facilities for disturbed children bears most unfavourably upon the welfare of wards in training schools. Arranging the care of these patients in Ontario Psychiatric Hospital facilities is a



hit-or-miss situation depending upon personal trust and communication between training school psychiatrist and the medical director of the psychiatric hospital or institute. Proper care for the seriously disturbed or depressed child or adolescent is at present difficult to arrange.

The Ministry should support children's psychiatric units in strategically placed university affiliated Ontario hospitals and psychiatric facilities; resources must be found to establish or expand child psychiatric units which will include care for sick children from training schools.

Decisions regarding external security and locked wards for a child sick enough to transfer to hospital should remain the responsibility of the medical director of the hospital unit and his staff and in keeping with legal requirements. Measures of external security should be available to the hospital medical director and his staff.

At one of the training schools, ongoing major psychiatric problems, and some medical problems, remain a feature in spite of the generous professional commitment of two part-time psychiatrists. The conclusion of the Committee is that both these dedicated part-time psychiatrists should be encouraged and should not be disturbed. The establishment of McMaster Health Sciences Centre has created a new resource in the area.

It is recommended that the Ministry should seek affiliation for Sprucedale and White Oaks Village with McMaster University and the health sciences complex and hospitals; also the Ministry

should seek the affiliation with McMaster of Hillcrest School in Guelph, the maximum security school for boys, and of Grand View School in Galt, the school for girls, presenting the most difficult behavioural problems. These three training schools have children with complex problems to solve requiring medical, psychiatric, psychological and social skills. Affiliation with McMaster University would contribute to ongoing progress in their care.

Ministry policy for adult mental health services

The Committee agrees with the following judgments by the psychiatric consultant: "There does not appear to be any overall direction from the Ministry and each superintendent appears to direct his psychiatric staff, in accordance with his assessment of the priorities and undoubtedly with the aims, interests and special skills of each professional, influencing such duties."

Professor Chalke has also noted an unacceptable degree of variability from institution to institution of working accommodation for psychiatric services and of consulting psychiatric services. The consultant in nursing has emphasized the lack of psychiatric training of the nursing staff in institutions and the Guelph Neuro-Psychiatric Clinic.

The Committee believes that to accomplish the development and implementation of an effective Ministry policy for psychiatric services that the need is inescapable for an Executive Director of Health Services and for consultants in adult psychiatry and in child psychiatry.

The Committee also has corroborated the judgment of Professor Chalke concerning "... ignorance or disregard both by administration and medical staff in some settings of the roles, responsibilities and competencies of various members of the 'psychological' professions, i.e, psychometrists, psychologists, psychiatrists and psychiatric social workers". Psychologists and sometimes psychometrists, most often of necessity, are undertaking individual inmate/patient responsibility for which they are not equipped professionally.

Inter-relationship of psychiatric services variously  
supplied by Ministries of Correctional Services,  
Health and Attorney General: Absence of integrated policy

(i) Provision of psychiatric services to the inmate/ward

"There are... a variable number of inmates who fall within the mandate of both the Ministry of Correctional Services and the Ministry of Health. Dependent solely upon local arrangements.... local cooperation, an individual may or may not be expeditiously and appropriately handled." (Chalke)

(ii) Funding of Services

"In one locality there is support, through funding to community agencies by the Ministry of Health, to provide in-patient and out-patient services to adult courts, to probation services, to correctional medical services and aftercare services (Clarke Institute out-patient services). Similarly Ministry of Health funds provide to some Family and Juvenile Courts, (and not to others, EHB) extensive clinical pre-sentence and treatment services for juveniles. These initial

examinations provide, when available, valuable contributions to the training schools when children are admitted. In the absence of stated policies, the basis of funding, e.g. per capita? caseload? number of regional courts?, is not available and hence appropriate community agencies cannot rationally plan such services with the local courts and correctional institutions." (Chalke)

(iii) Provision of services to the Courts

The practice of utilization of Ministry of Correctional Services psychiatrists for adult courts depletes the already inadequate Ministry psychiatric services to sick prisoners. It also "...makes it difficult to obtain the services of psychiatrists interested primarily in clinical care of ill prisoners..." (Chalke)

The Committee recommends that a policy should be developed regarding the provision of psychiatric services to both the Ministries of Justice and Correctional Services by the Ministry of Health. Effective inter-Ministry cooperation should currently exist in the provision of psychiatric services.

The following specific proposals are made:

Psychiatric services for adult ambulatory patients

Jails, regional detention centres and correctional centres --  
A substantial increase should be made in the provision of psychiatric services. Ambulatory patient care should be expanded. Additional provision is proposed for services to courts and for any responsibility for the care of ill patient/inmates in related mental health

institutions. The medical officer, the nursing staff, psychologist, social worker and the correctional staff, all should have the benefit of advice and education from an involved and interested psychiatrist. He should serve the institution as psychiatric consultant to the extent of at least one-half day for each unit of 40 inmate capacity to provide effective service. He should be related to the regional psychiatric units. (Page 171)

With the development of medium security regional psychiatric units, with Penetanguishene for sick inmates requiring maximum security and temporary absence plans for minimum security inmates, there should be little need for Ministry clinics of the type now operated at Guelph.

At the present time Guelph Correctional Centre and Guelph Neuro-Psychiatric Clinic constitute a unique situation for several reasons: The reception of first incarcerates and all young (16-18) offenders; the large inmate population of Guelph Correctional Centre; the effectively non-existent psychiatric consulting services in Burwash, Millbrook and Rideau Correctional Centres.

The Committee judges that the needs of Burwash, Millbrook, Rideau and Guelph for psychiatric consultations and treatment should be met largely by visiting psychiatric consultants. Medium security inmate/patients should be admitted to regional psychiatric units in selected Psychiatric Hospitals as recommended.

It follows that no new neuro-psychiatric clinics should be established and Guelph Neuro-Psychiatric Clinic should be phased



out as new consulting services and regional treatment units in hospitals are developed.

The optimum function of the Central Ontario Clinic proposed for the comprehensive health examination of first incarcerates and all young (16-18) offenders requires that it include consultative psychiatric capabilities of the highest quality. It is proposed that this responsibility should be accepted by transferring to Brampton staff from the existing Neuro-Psychiatric Clinic and providing enlarged diagnostic resources. Psychiatric patients should not be transferred from jails, regional detention centres and correctional centres to the Central Ontario Clinic at Brampton but should be treated as already described by psychiatric consultants and in regional psychiatric units.

Treatment in Ontario psychiatric adult facilities for  
patient/inmates - regional psychiatric units

In Ontario psychiatric hospitals, the elimination of locked wards for acutely disturbed patients creates security difficulties in the case of some "medium security" inmate/patients. It must be added that the presence of guards on general hospital psychiatric units or psychiatric hospital wards is judged by the psychiatric staff, and with reason, to disturb the general atmosphere and to be undesirable. As a result resistance generally exists to the admission of psychiatrically ill inmates to Ontario Psychiatric Hospitals who, in the opinion of the superintendent of the correctional institution or hospital staff, require medium security. The

Clarke Institute and the Mental Health Centre in Penetanguishene are exceptions and there are probably others unknown to the Committee. The need exists for expanded psychiatric hospital facilities for patient/inmates judged to need "medium security".

The Committee recommends the development of regional psychiatric units, related to correctional institutions within the framework of existing psychiatric facilities in the Province and selected from university affiliated Ontario Psychiatric Hospitals and other university affiliated psychiatric facilities, e. g. Clarke Institute, Royal Ottawa Hospital. These regional psychiatric units should be planned jointly by the Ministry of Correctional Services, the Ministry of Health, the hospital(s) concerned and the university regional health sciences complexes.

They should be capable of providing custody to the medium security level. (Patient/inmates requiring maximum security and referred outside the institution for psychiatric examination and/or treatment, should be transferred, as at present, to the Oak Ridges Centre at Penetanguishene.)

Encouragement in the form of staff and facilities to develop treatment units to admit and care for these patient/inmates should be offered -

- (i) to psychiatric hospital medical directors in selected strategically located Ontario psychiatric hospitals affiliated with university health sciences complexes; (Queen Street Mental Health Centre, Toronto; Hamilton Psychiatric Hospital; Mental Health Centre, Penetanguishene; Kingston Psychiatric Hospital; London Psychiatric Hospital);

- (ii) to directors of other psychiatric facilities such as the Clarke Institute and the Royal Ottawa Hospital.

The appurtenances of medium security must be provided to be used as the medical director and medical staff judge necessary and in keeping with legal requirements.

The Committee recommends that a clear policy be evolved jointly by the Ministries of Health and Correctional Services and university affiliated psychiatric facilities as to criteria for admission and responsibility for custody for referred inmate/patients. The Committee believes and recommends to the Ministry that patient/inmates admitted to regional psychiatric units should be the full and total responsibility of the regional psychiatric units.

The Committee foresees the following among the functions that such units could fulfill for the Ministry of Correctional Services:

- (i) Receive and treat the acutely and severely ill inmates referred (with the concurrence of the correctional institution's psychiatric consultant when available) by the medical services of the Ministry in its catchment area.
- (ii) Provide psychiatric observation, refinement of diagnosis and initiate treatment in the regional psychiatric unit; evolve and communicate the continuing treatment plans for these inmates through the Ministry psychiatric consultants and to the Ministry institutional medical service.

- (iii) The provision when necessary of regional psychiatric unit in-patient confirmation of diagnosis and initiation of treatment; assignment to special Ministry institutional program for those considered by the Ministry institutional psychiatric consultant to be suffering underlying psychopathology, e. g. masked depressions, latent schizophrenias clearly related to the offence or offences.
- (iv) All patients, before transfer to the Alex G. Brown Clinic because of drug abuse, alcoholism or sexual deviancy, should be considered by the institutional psychiatric consultant and if indicated in his opinion by the regional psychiatric unit.
- (v) The assessment of those with major psychiatric disabilities when the correctional institutional psychiatric consultant requires advice as to the most suitable programs for their rehabilitation while under sentence.
- (vi) The provision, by mutual agreement between the correctional institutions, the regional psychiatric units, and inmate, of special psychiatric programs. These should attempt to modify, ameliorate, treat or study on a trial or pilot basis individuals considered suitable, e. g. patients with brain injury and episodic violence, some sex offenders, incestuous patients, arsonists, etc.

The Committee considers that there are major advantages to sick inmates in this proposal for dealing with the problems of patient/inmate care; the alternative would consist of the Ministry attempting, on its own, to operate one or more specialized, isolated, health facility(ies) outside the main stream of the psychiatric services in Ontario and within the jurisdiction of the Ministry of Correctional Services.

These advantages include:

- (i) Proper standards of medical care in a specialized field can be consistently and better maintained in the context of health institutions than within the jurisdiction of Correctional Services.
- (ii) Provision of psychiatric care to inmate/patients near their homes and facilitating contact with their family or friends and likely places of re-establishment.
- (iii) It will benefit inmate/patients to be able to bring to bear the total clinical competences available in agreed upon university affiliated psychiatric facilities.
- (iv) It will provide an opportunity for the Ministry institutional psychiatric consultants and other professional staff to maintain personal and professional contact with the staff of their regional psychiatric units; to hold, when appropriate, appointments there; to participate in the planning of care on return of inmate/patients, etc.
- (v) It will widen the training facilities in correctional psychiatry, by making available one or more units in the network area of most of the health sciences educational complexes.
- (vi) Regional psychiatric units should enable nurses and specialized social workers and psychologists, as well as physicians, to upgrade their continuing education in forensic psychiatry.
- (vii) Research in forensic psychiatry should be improved and facilitated.
- (viii) The cost-benefits of care of inmate/patients in psychiatric hospital should be improved by the avoidance of the duplication of hospital services.



- (ix) The cooperative integration of the psychiatric services of the Ministry of Correctional Services with the Ministry of Health. This is in accord with the statement made by the Minister of Health, the Honourable Richard T. Potter, M.D. -

"Concepts for the Future

A comprehensive program will be required, capable of serving the needs of the total population, without limitation or restriction by age, nature of illness or any other criteria. Such a program must be developed on a broad base and make full use of all the technical knowledge and skills available."

The Committee anticipates that the regional psychiatric units of the Ministry of Health in university affiliated Ontario psychiatric facilities could develop, in the same physical setting, arrangements with the Department of the Attorney General to fulfill the forensic psychiatric services for adults required by that Department.

Guelph Neuro-Psychiatric Clinic

The Committee proposes that the Guelph Neuro-Psychiatric Clinic should become the diagnostic psychiatric division of the Central Ontario Clinic - the health reception and assessment centre at Brampton. It should not receive patients transferred from jails, regional detention centres or adult correctional centres. The psychiatric and psychologic staff should maintain and, if possible, expand their consulting services in jails and adult correctional centres and be related to the appropriate regional psychiatric unit.

Alex G. Brown Memorial Clinic

In this clinic for the treatment of the drug addict, the alcoholic and the sexual deviant, the objective is to effect "...positive changes in the areas of personality, attitude and behaviour..." as recorded by Dr. Boothroyd (Appendix D). He goes on to note:

- " 6. There is an almost universal desire on the part of staff to become more skilled in their relationship management and more knowledgeable about the whole area of 'helping others'."
- " 7. There is a less prominent realization of the need to evaluate the results of their efforts and to discover what indeed they are accomplishing in terms of the short or long term effects on the individuals under their care. Awareness that evaluation techniques are available seems to be lacking..."

The A.G. Brown "...appears to represent a specific therapeutic program for selected individuals with certain assets and motivations, and could be seen as one specialized program within the overall clinical (mental health) programs of the Ministry." (Chalke, Appendix B)

The need for selectivity of individuals accepted for treatment is supported by Shireman, et al.\*, who reviewed and assessed the findings of some of the projects having to do with testing the treatment of offenders in correctional institutions, juvenile and adult, in the United States. Projects were limited to those endeavours in

\*"Findings from Experiments in Treatment in the Correctional Institution" - Charles H. Shireman, Katharine Baird Mann, Charles Larsen and Thomas Young, Social Service Review, Vol. 46, No. 1 (March 1972) pp 38-59.

the U.S.A. completed within the ten years prior to 1968-69.

Projects directed at "the treatment of addiction were also ruled out". A further restriction was "limitation of the study to the examination of treatment modalities that had been subjected to research employing some form of evaluative experimental design... target treatment group;...experimental treatment and control groups... sound sampling techniques."

No studies reviewed the effectiveness of institutional versus non-institutional care.

The authors point out that many projects in most of these treatment forms (milieu therapy, group counsellors, individual short-term psychotherapy, plastic surgery) have failed, but more importantly, "...some experimenters, working under some conditions, have demonstrated that treatment can be effective with considerable proportions of subject groups. This has been true of some projects in most of the treatment forms considered."

The Committee supports the following from Dr. Boothroyd's report (Appendix D, Recommendation 13):

" 13. That the primary goal of the Alex G. Brown Memorial Clinic be: to develop, enhance, and disseminate knowledge about the care of inmates/wards who have problems related to drug (including alcohol) use. Accomplishment of this goal will include (but not be confined to) achievement of the following objectives:

(a) Critical evaluation of the "treatment methods" presently in use in the Clinic itself.....

- (b) Development and testing of model programs which are effective and feasible for local institutions.
- (c) Participation in the relevant education of staff throughout the Ministry.

This primary goal does not exclude the other activities of the Clinic, as, for example, its important work in the area of sexual deviations."

The Committee also recommends that -

- (i) The Alex G. Brown Memorial Clinic should not increase in size or expand the range of treatment services until the effectiveness of current treatment services have been assessed by a prospective plan of research employing planned evaluative experimental design.
- (ii) The collaboration of the Addiction Research Foundation should be sought in planning such research. The Addiction Research Foundation over a number of years has developed a model for systematic study of the effectiveness of various methods of treating alcoholics.
- (iii) The director of treatment services (not the superintendent) in the A.G. Brown Clinic should be licensed and specially qualified physician.
- (iv) Inmates for whom transfer to the A.G. Brown Clinic is proposed should have a health examination and psychiatric assessment before transfer.
- (v) The role and professional responsibility of the non-medical treatment team-manager, his non-medical professional team colleagues, and the physician on the team if there is one, should be defined and agreed upon and conform to Ministry health services policy.
- (vi) If there is no medical doctor on the team, the concurrence of the medical officer should be a requirement before the program is initiated.

Dr. Chalke, in his report (Appendix B) notes:

"In some settings the psychiatrist applies the medical model in his relationship to other staff, whether he operates through the medical department or not, and assumes the responsibility as a physician for those under his care. In other cases he generally assumes a position on a team undertaking modification of a social deviancy without himself or anyone else, assuming a position of professional responsibility."

The Committee recommends that -

- (vii) The health of an individual in custody and under therapy, often intense and stressful, should be the responsibility of an individual physician or nurse practitioner with appropriate psychiatric training working under the supervision of the physician.

#### Psychiatric staff

In conclusion, the Committee recommends the following as measures necessary to expand the psychiatric staff and consulting psychiatric services to a level of effectiveness acceptable to the Ministry:

- (i) Financial educational grants for psychiatrists on a return-of-service basis;
- (ii) Sessional indemnities and full-time salaries commensurate with the returns of private consulting practice;
- (iii) The professional support of helpful Ministry consultants;
- (iv) Affiliation whenever appropriate of Ministry institutions with universities and their affiliated hospital groups.



### 3. Alcoholism and drug dependence

#### Alcoholism (Kenora and Thunder Bay Jails)

The Kenora Jail, in a city of about 12,000 people, had in 1971 the fourth largest total (200 less than third largest) of inmate days - 35,649 - of all Ontario jails. This is directly attributable to the frequency with which Indians are sentenced to jail, men and women, and most commonly arising out of drunkenness. Numbers of admissions and transfers and the toxic effects of alcoholism constitute a special problem for the doctor, who is part-time and works without nursing or other assistance, even to weighing individuals, counting the pulse and testing the urine for sugar and albumin.

In Thunder Bay Jail drunkenness and toxic effects of alcohol present similar qualitative problems and the jail has, in addition, the acute problems that go with serving as a lock-up.

General hospitals and Ontario Psychiatric Hospitals have commonly placed a low priority, or resisted admitting the alcoholic patients with incipient or frank delirium tremens. Facilities and staff in jails, and in jails serving as lock-ups, are generally inadequate and unsatisfactory for the care of the alcoholic. The problem is the patient with diminishing drunkenness but with deteriorating cerebral function, with incipient D.T.'s, or other complications.

The development of detoxication units outside the jail, and which will receive the individuals suffering from acute alcoholism instead of lock-ups and jails serving as lock-ups, should result in

more effective care of the alcoholic. Each detoxication unit will be a unit of a general hospital with its broad range of diagnostic and therapeutic resources, available to support the care of the patient with alcoholism.

The recommendation is made that, until detoxication units of general hospitals are operational throughout the province, the Ministries of Health and Correctional Services should ensure that provision is made for admission to a general hospital of jail patients who have the complications of alcoholism.

Problems associated with the use of alcohol and other drugs

The report of Dr. W.E. Boothroyd, consultant to the Committee, is appended as Appendix D. The term 'drugs' is taken to include alcohol, marihuana, hallucinogens, amphetamines, sedatives, opiates and substances that are sniffed. Dr. Boothroyd's report contains an admirable short discussion as to the kind of problem presented in addition to his report of some observations made in the course of his visits. The Committee recommends consideration of his theoretical discussion by health services staff and correctional staff alike.

The Committee generally endorses and supports Recommendations 1-14 of Appendix D.

The Committee places emphasis on:

- (i) The involvement of members of the local community at large, e.g. A.A. in contributing to the care for inmates/wards who have problems related to drug (including alcohol) use.

- (ii) The continuing education by all possible means of all staff with regard to the provision of appropriate care for inmates/wards who have problems related to drugs (including alcohol).
- (iii) The utilization by the Ministry of personnel and other resources, treatment, teaching and research, of the Addiction Research Foundation to the maximum possible extent.

#### 4. Drugs: Dispensing and administration of drugs

Narcotics and controlled drugs should be the responsibility of the nurse in regional detention centres and larger jails. In the absence of a Ministry nurse, only correctional officers properly qualified as a "hospital officer" should be permitted to administer controlled and household drugs. If narcotics are prescribed, a Ministry nurse, or possibly the Victorian Order visiting nurse, should be called to undertake this duty.

Controlled drugs administered by the correctional staff member - "hospital officer" - should be dispensed in individual doses by one of the following:

- (i) A Ministry pharmacist, if one is available, using a system such as that evolved by the pharmacist (Appendix G) of the Toronto Jail which is evidently working satisfactorily.
- (ii) A Ministry nurse utilizing a system such as that of the Toronto Jail.
- (iii) A local pharmacist if expense is not excessive.
- (iv) A Victorian Order visiting nurse.

In the event that none of the above possibilities can be implemented, drugs should be dispensed only by a registered nursing assistant or correctional officer trained as a "hospital officer".

#### 5. Dental care

The further development of dental care services by the Ministry as outlined by Dr. D.W. Lewis is regarded by the Committee as highly desirable on grounds of health. The expanded development of dental services is in keeping with the current views of the "blue collar" segment of the community, labour unions, as well as the "white collar" segment.

Inmates in adult correctional institutions appreciate the dental services they had received and it seemed to make a positive contribution to morale. The desirability of dental care services in training schools is self-evident.

The terms of reference for this part of the enquiry were described by the Minister of Correctional Services, the Honourable C.J.S. Apps, as -

"to inquire into the Dental Care Services role of the Dentists available and needed to fulfill the "Statement of Purpose" of the Department. This will include examining the needs of the Department in the forthcoming decade. The utilization of auxiliary personnel as a means of providing an increased volume of dental services with minimal increased costs requires special consideration. Included also should be consideration of provisions for continuing educational programs to ensure a high level of ongoing professional competence of the full time Dental Staff."

The report on dental care services is appended. Noteworthy are Dr. Lewis' independent observations regarding the variability of means of entry into the dental care service and variation in policy regarding inmate payment for dentures.

The Committee supports the recommendations made in this report and the Summary of Recommendations is concise enough to permit reproduction here for convenience. (Page 186)

The Committee emphasizes specially that dental staff and facilities should be expanded (iii), and existing anomalies in dentist supply among institutions should be corrected (vii). The development of full use of existing and new types of dental auxiliaries (ix) deserves high priority by the Ministry.

The revision of the planning of dental facilities as they appear in Quinte and Ottawa-Carleton Regional Detention Centres should be undertaken immediately. Such facilities should make provision for employment of the modern dental hygienist and a two-dental operatory set-up.

Revision of existing plans for dental facilities in correctional centres and for new adult institutions and training schools should be developed with the Consultant-Coordinator for Dentistry and the Executive Director of Health Services. Improved quality of dental care and cost benefits are possible only with modern facilities and the assistance of dental auxiliaries.



SUMMARY OF RECOMMENDATIONS \*  
(Dr. Lewis' Report on Dental Care)

Service and Patient Aspects

- i. Clarification of dental treatment guidelines and development of an effective means of communicating these is necessary (47, 48, 49).
- ii. Existing variations within each institutional category in patient entry to dental care services and treatment available should be removed (50, 53).
- iii. Dental program staff and facilities should be expanded to accommodate anticipated future increased demands and to permit virtually all inmates to have an initial oral examination (51).
- iv. Preventive services should be routinely available to, and promoted for, inmates (52).
- v. Consultation with, and referral of patients to, dental specialists should be available for each institution (54).
- vi. Policy variations in respect to inmate payment for dentures should be standardized in favour of no payment; protection from inmate abuse of the prosthetic service should be by guideline and an effective follow-up record system (55, 56).

Staff Aspects

- vii. Existing anomalies in dentist supply among institutions within each institutional category should be removed (57).
- viii. Chairside dental assistants should be routinely available to dentists (58, 59).
- ix. Full use of existing and of new types of dental auxiliaries with expanded duties as these become available, should be made (60).
- x. Bursary support by the Ministry for persons undergoing undergraduate auxiliary training to ensure an adequate supply of auxiliaries (including dental hygienists) for the dental program is advisable (61).
- xi. Salary scales of dentists and dental auxiliaries should be competitive with private practice if good people are to be recruited and kept (62).
- xii. A full- or part-time dental educator (preventive dental assistant or dental hygienist) should be employed by the Ministry to develop and carry out a dynamic educational program for small groups in training schools and for selected groups in other institutions (63).
- xiii. Dental staff association with adjacent hospitals, clinics and other institutions should be encouraged (64).
- xiv. An extensive, dynamic continuing education program for dental staff should be established (65).
- xv. A part- or full-time dental program co-ordinator should be employed (66).

Facilities, Supplies and Equipment

- xvi. The feasibility of expansion of existing institutional dental facilities to two chair units should be studied (67).
- xvii. New facilities should have two dental operatories and professional consultation regarding the efficiency of office arrangement should be sought prior to the development of new facilities (68, 69).
- xviii. Improved arrangements for ordering dental supplies are necessary (70, 71).

\*The figures in brackets at the end of each recommendation are the paragraph numbers in the Dental Consultant's Report (Appendix C), where more detail is given. Also, the appropriate section in the Report provides some of the necessary background information for the recommendations.

6. Sick parade problems including use of nurses and inmates and records

Inmates acting as hospital orderlies working in the correctional centre "hospital" and at sick parade has concerned nursing staff, the Committee and the consultants. Inmates should be precluded from filing or handling their own or other inmates' health records. Inmates acting as "nursing orderlies" at sick parade have been observed using poor medical, antiseptic and aseptic technique. The presence is unacceptable of inmate orderlies and inmate patients waiting in the sick parade room or closely adjoining open communicating space, to take their turn. These circumstances destroy professional privacy for staff and patient. Generally, the use of inmates for health care duties should not be encouraged.

Sick parade: Physical facilities: Privacy of communication

Physical facilities for sick parade should ensure professional privacy and, as may be necessary, the security of professional staff. Correctional staff should not be put in a position where they cannot avoid listening, or appearing to listen to the conversation between inmate and physician or nurse at sick parade. Wherever necessary measures should be taken to ensure privacy of communication between inmate and physician or nurse.

Medico-legal problems in sick parades  
conducted by nurse practitioner

Currently, the professional opinion of the nurse is lacking in medico-legal significance in the Ministry. The opinion of the nurse that an inmate is fit to work does not warrant a charge should he refuse to work. The nurse's sick parade on the days the physician does not attend the centre may be relatively large and contain a significant number of individuals claiming they are unable to work because of a variety of symptoms which the nurse judges do not require medical or nursing intervention: "doing a stall".

Conducting such a sick parade is no less unattractive for the nurse practitioner than it is for the physician. Inescapably it influences adversely the quality of the health services. Over a period of time every inmate at sick parade becomes suspect of "stalling".

The genuinely ill suffer sooner or later.

7. Health of Superintendents

Earlier in this report reference was made to the stressful way of life of superintendents of adult institutions and some training schools. Dating from the earliest visits, signs of stress have been observed in a number of superintendents, men of conscience, integrity and administrative ability. The health of the superintendent is of great and special importance to his institution. His leadership and example are the major factors in developing the morale, the effectiveness of the Ministry rehabilitation program, and even

influencing the number of inmates attending sick parades attempting to do a "stall".

Many civilian corporations make special efforts to protect the health of their senior executives and to facilitate their work. It is recommended that the Ministry should maintain under systematic review the health status, working conditions, including provisions for leave, and support services for the superintendents.

8. Health services personnel and expenditures;  
variability among institutions and schools

Reference has already been made (Pages 110, 119, 122, 123) to variability among institutions and schools in the health services staff resources, particularly in relation to inmate and student populations. The observed variability appears to be a manifestation of lack of staffing guidelines and the nature of the individual institutional response to problems of health. The difficulty of establishing personnel standards is recognized in view of the generally small institutional populations, their locations, and movement of wards and inmates (see Pages 13, 14 and Table 1). The development of practical staffing guidelines on the basis of individual institutional need and in conformity with Ministry policy might well be a subject for early attention by the Executive Director and his Health Services Advisory Board. There is a conspicuous lack of administrative resources at Ministry Headquarters for this kind of development of a system of health care delivery.



The expenditures of the Ministry of health services are substantial, nearly \$2 million, but are only a small part - about 3% of total Ministry expenditures. Some data for the year ending March 31, 1972, are given in Table 20. Included in these health expenditures are salaries for doctors, dentists and nurses, fees for professional services, hospitalization charges, medical, dental and pharmaceutical supplies and equipment costs. Nearly 80% of the total health expenditures went for medical services, 12% for psychiatric services and 7% for dental services. Although administrative (Main Office) expenses for the Ministry amounted to nearly 6% of all expenditures, the Main Office accounts for only 2% of all health expenditures. Nearly three-quarters (73.5%) of health expenditures were for adult offenders and one-quarter for juveniles which is similar to the distribution of all expenditures (66.7% and 27%). More detailed information is given in Appendix 10 but some basic data for institutions and schools are shown in Tables 22 and 23.

Professional salaries and fees are the major component of health services expenditures so that variations among institutions and schools may reflect differences in staff resources. The health personnel data are summarized in Table 21 with more detail in Appendix 10. The health personnel are distributed about one-third in jails, one-third in other correctional institutions, and one-third in training schools. This does not correspond with the workload as presented by the numbers under care during the year, the admissions, or the average daily population (Table 1, Page 15),



TABLE 20

MINISTRY OF CORRECTIONAL SERVICES  
EXPENDITURES ON MEDICAL, DENTAL AND PSYCHIATRIC SERVICES  
FOR THE YEAR ENDING MARCH 31, 1972

	<u>Expenditures</u>		<u>Percentage distributions</u>	
	<u>All programs</u>	<u>Health services</u>	<u>% Total all programs</u>	<u>% Total health services</u>
1. Departmental administration (Main Office)	\$ 3,711,189.36		5.98	
08 Medical, dental and psychiatric		\$ 30,641.18		1.60
2. Rehabilitation of adult offenders	41,386,454.59		66.68	
06 Medical services		\$1,187,768.69		
07 Psychiatric services		143,102.87		
08 Dental services		78,241.98		
Total - 2.06 + 2.07 + 2.08		<u>\$1,409,113.54</u>		73.53
3. Rehabilitation of juveniles	16,965,942.14		27.34	
06 Medical services		\$ 333,500.61		
07 Psychiatric services		87,608.76		
08 Dental services		55,532.55		
Total - 3.06 + 3.07 + 3.08		<u>\$ 476,641.92</u>		24.87
<u>TOTAL</u>	<u>\$62,063,586.09</u>	<u>\$1,916,396.64</u>	<u>100.00%</u>	<u>100.00%</u>
<u>Distribution of medical, psychiatric and dental expenditures</u>				
2.06 + 3.06 Medical services		\$1,521,269.30	2.45	79.38
2.07 + 3.07 Psychiatric services		230,711.63	0.37	12.04
2.08 + 3.08 Dental services		133,774.53	0.22	6.98
<u>TOTAL - Medical, psychiatric and dental services</u>		<u>\$1,885,755.46</u>	<u>3.04</u>	<u>98.40</u>
1.08 (Main Office) medical, psychiatric and dental services		30,641.18	0.05	1.60
<u>TOTAL MEDICAL, PSYCHIATRIC AND DENTAL SERVICES</u>		<u>\$1,916,396.64</u>	<u>3.09%</u>	<u>100.00%</u>

TABLE 21

HEALTH SERVICES POSITIONS AND APPOINTMENTS\*  
DISTRIBUTION BY EMPLOYMENT CATEGORY AND TYPE  
Correctional Centres, Jails and Training Schools

Category	Type of appointment	Correctional Centres (incl. A.T.C., Clinics and Camps)	Jails	Training Schools	Total	% of Total
Physicians	Full-time	5	2		7	2.83
	Part-time	9	42	11	62	25.10
	Sessional	2	1	1	4	1.62
	Fees	5		3	8	3.24
	Other		1		1	0.40
	Total	21	46	15	82	33.19
Psychiatrists	Full-time	1	1		2	0.81
	Sessional	8	1	11	20	8.10
	Fees	1	4	2	7	2.83
	Other & unspec.	1		2	3	1.21
	Total	11	6	15	32	12.96
Dentists	Full-time	2			2	0.81
	Shared FT	5	3	5	(4) 13*	5.26
	Part-time			2	2	0.81
	Sessional	1		3	4	1.62
	Fees	2	10	2	14	5.67
	Unspecified			2	2	0.81
	Total	10	13	14	(28) 37*	14.98
Nurses	Full-time	25	13	31	69	27.94
	Part-time	4	1	7	12	4.86
	Other & unspec.			3	3	1.21
	Total	29	14	41	84	34.01
Others**	Full-time	3	4	1	8	3.24
	Part-time		1		1	0.40
	Fees	3			3	1.21
	Total	6	5	1	12	4.86
TOTAL	Full-time	36	20	32	88	35.63
	Shared FT	5	3	5	13*	5.26
	Part-time	13	44	20	77	31.17
	Sessional	11	2	15	28	11.34
	Fees	11	14	7	32	12.96
	Other & unspec.	1	1	7	9	3.64
	TOTAL	77	84	86	247	100.00%

\* Incl. 4 positions vacant: psychiatrists 2; dentists 2; excl. Director of Medical Services.  
4 dentists employed full-time share 13 positions; dentists FT 6 - Total 28.

\*\* Others include: secretaries 3; typists 2; pharmacist 1; radiographer 1; medical clerk 1;  
PH officer; optometrists 3.

Source: Based on Nominal Roll, Medical Services Branch, Feb. 1972.

although the proportions are closer to the latter, represented by the population count, than to the former two measures.

One-third of the health personnel are physicians (other than psychiatrists) and over half of them serve jails but mainly on a part-time basis; in all, 75% of doctors are part-time. Most of the psychiatrists are paid on a sessional basis; others by fees. The fee basis often means merely being called for a particular case without regular involvement in the institution or school. This applies to many of the dentists, but six dentists do serve on a full-time basis. The nurses comprise the largest group of full-time personnel (69/88) and they are distributed among the correctional centres 25, training schools 31, and jails 13 - of the latter, 12 are in the Toronto Jail. The health personnel serving any one institution are generally few in number, half a dozen or less, the exceptions being Toronto Jail, Mimico and Guelph Correctional Centres with their associated clinics and camps, the Vanier Centre for Women, Grandview School, St. John's School for boys. The variety of types of appointments and the preponderance of other than full-time staff are noteworthy points. Data for both health personnel and health expenditures are shown for correctional institutions in Table 22 and for training schools in Table 23, with more detail in Appendix 10.

It is evident from these data that over half of the health expenditures in institutions and schools are for salaries and these, with fees for professional services, account for about 80% of correctional centres expenditures and nearly 90% for training schools

TABLE 22

INMATE POPULATION, HEALTH SERVICES STAFF AND HEALTH SERVICES  
EXPENDITURES OF ADULT INSTITUTIONS (EXCLUDING JAILS) 1972

A. SELECTED BASIC DATA

Institution (C.C. or A.T.C.)	Inmate population count 2/4/72 (1)	Health services staff		Health services expenditures	
		Full-time (FT) (2)	Total (3)	Personnel (4)	Total (5)
Vanier CC & Toronto Unit	112	5	12	\$ 86,503.90	\$ 98,277.24
Burtch CC & ATC	175	1	3	29,904.82	50,816.11
Burwash CC and Camp	431	7	8	142,622.15	165,127.71
Guelph CC and N.P.C.	682	15	20	161,760.75	202,687.11
Millbrook CC	174	1	5	26,279.36	41,393.38
Mimico CC, A.G.B. & Camp	310	4	11	147,243.05	194,711.22
Monteith CC and ATC	143	1	5	26,003.96	29,254.99
Rideau CC and ATC	138	1	3	31,249.62	45,165.68
Thunder Bay CC and ATC	100	-	3	4,167.85	4,933.61
Brampton ATC	135	1	4	38,904.39	45,089.29
TOTAL (including camps)	2,420	36	77(3)	\$694,639.85	\$877,456.34

B. RATIOS ILLUSTRATIVE OF VARIABILITY AMONG INSTITUTIONS

Institution (C.C. or A.T.C.)	Inmate / Health services population / staff		Total health services expenditures	Health Services personnel expenditures
	Inmates FT staff (1) ÷ (2)	Inmates Total staff (1) ÷ (3)	Inmate population (5) ÷ (1)	Total health services staff (4) ÷ (3)
Vanier CC & Toronto Unit	22.4	9.33	\$877.43	\$ 7,208.66
Burtch CC and ATC	175	58.3	290.38	9,968.27
Burwash CC and Camp	61.6	53.9	383.13	17,827.77
Guelph CC and N.P.C.	45.5	34.1	297.20	8,088.04
Millbrook CC	174	34.8	237.39	5,255.87
Mimico CC, A.G.B. & Camp	77.5	28.2	628.10	13,385.73
Monteith CC and ATC	143	28.6	204.58	5,200.79
Rideau CC and ATC	138	46	327.29	10,416.54
Thunder Bay CC and ATC	-	33.3	49.44	1,389.28
Brampton ATC	135	33.8	333.49	9,726.10
ALL INSTITUTIONS	67.2	31.4	\$ 362.59	\$ 9,021.30

Sources: Inmate Population - Ministry Adult Institutions Count Sheet, April 2, 1972.  
Health Services Staff - Nominal Roll, Medical Services Branch, Feb. 1972.  
Health Services Expenditures - Data provided by the Office of the Ministry  
Chief Accountant, for the year ended March 31, 1972.



TABLE 23

STUDENT POPULATION, HEALTH SERVICES STAFF AND  
HEALTH SERVICES EXPENDITURES OF TRAINING SCHOOLS, 1972

A. SELECTED BASIC DATA

Training School	Student population count 2/4/72 (1)	Health services staff		Health services expenditures	
		Full-time (FT) (2)	Total (3)	Personnel (4)	Total (5)
Grandview & R&DC	144	6	12	\$110,802.50	\$130,180.27
Kawartha Lakes	68	3	7	40,283.37	45,728.22
Elmcrest (St. Euphrasia's)	83	4	8	22,197.96	25,218.14
Trelawney House	16	-	3	2,564.90	3,071.61
Brookside	123	3	6	49,150.54	53,324.86
Cecil Facer	119	3	5	21,043.24	28,059.51
Glendale	53	3	7	33,287.51	34,773.74
Hillcrest	46	-	4	14,037.16	14,778.51
Pine Ridge (& Coldsprings)	143	3	7	56,093.05	61,295.04
St. John's	117	1	11	-	-
St. Joseph's	67	3	6	-	-
Sprucedale (& White Oaks)	119	3	3	70,588.94	76,766.36
Total (incl. Project D.A.R.E.)	1,179	32	96	\$420,212.28	\$476,641.92
(Excl. St. John's & St. Joseph's)	(995)	(28)	(69)		

B. RATIOS ILLUSTRATIVE OF VARIABILITY AMONG SCHOOLS

Training School	Student / Health services population / staff		Total health services expenditures	Health services personnel expenditures
	Students FT Staff (1) ÷ (2)	Students Total Staff (1) ÷ (3)	Student population (5) ÷ (1)	Total health services staff (4) ÷ (3)
Grandview & R&DC	24	12	\$904.03	\$9,233.54
Kawartha Lakes	22.7	9.7	672.47	5,754.77
Elmcrest (St. Euphrasia's)	20.8	10.4	305.83	2,774.74
Trelawney House	-	5.3	191.98	854.97
Brookside	41	20.5	433.53	8,191.76
Cecil Facer	39.7	23.8	235.79	4,208.65
Glendale	17.7	7.6	656.11	4,755.36
Hillcrest	-	11.5	321.27	3,509.29
Pine Ridge (& Coldsprings)	47.7	20.4	428.64	8,013.29
St. John's	117	10.6	-	-
St. Joseph's	22.3	11.2	-	-
Sprucedale (& White Oaks)	39.7	14.9	645.10	8,823.62
All Schools (inc. Project D.A.R.E.)	36.8	13.7	\$404.28	\$4,886.19
(Excl. St. John's & St. Joseph's)			(479.04)	(6,090.03)

Source: Student population - Ministry Juvenile Schools Count Sheet, April 2, 1972.

Health Services Staff - Nominal Roll, Medical Services Branch, provided by  
Director of Medical Services, February 1972.

Health Services Expenditures - Data provided by the Office of the Ministry  
Chief Accountant, for the year ended March 31, 1972.



and for the Toronto Jail. The latter had a total health services expenditure of about \$250,000 - the largest of any one institution or school.

For correctional centres the range is from about \$200,000 for Mimico and Guelph with associated clinics and camps, to under \$5,000 for Thunder Bay Correctional Centre and Adult Training Centre.

The training schools health expenditures varied from about \$130,000 for the Grandview School and Reception and Diagnostic Centre to about \$15,000 for Hillcrest.

It is recognized that the various characteristics of the populations under care must be kept in mind in attempting to assess adequacy of health services in such terms as personnel and expenditures. Among the characteristics are the sex and age distributions (see Tables 2, 8, and 15; Pages 23, 50 and 69) and the population dynamics - admissions, discharges, transfers, the total under care or days of care, and the average population on any day. (Tables 1, 3, 10 and 16; Pages 15, 25, 53 and 70). An attempt has been made to assess the variability in health services personnel and expenditures among institutions and schools in relation to inmate/student population by comparing ratios of population to staff, expenditures to population and expenditures to staff. In order to use current (1972) data, the possible total population measures are reduced to population counts (April 2, 1972) and these are related to health services personnel for February 1972 and expenditures for the year ending March 31, 1972. Thus the data in Table 22 and Table 23 must be considered as only illustrative of the kinds of relationships present.

Notwithstanding the limitations of the data they are of substantial interest and a few pertinent observations may be made from these tables. In Table 22 the number of inmates per staff member runs from a low of 9 for Vanier to a high of 58 for Burtch. This situation held for both full-time and total staff. Centres such as Vanier with a low ratio of inmates to staff have a high ratio of health expenditure to inmate population; Vanier expenditures are \$877 per inmate while Burtch ratio was less than half of this - \$290, and Thunder Bay spent only \$50 per inmate. The latter had no full-time staff. The apparent disparity between Guelph and Mimico, both of which have associated clinics and camps, is noteworthy; it reflects the larger size of the A.G. Brown Clinic with an expensive staff engaged in this therapeutic milieu/community. Mimico spent more than twice as much for health services per inmate as did Guelph although both had spent about \$200,000 for health services. Guelph had twice as many inmates on April 2, 1972, but also had nearly twice as large a health staff; on the average Mimico staff costs about \$13,000 and Guelph \$8,000 per member of the health services staff. Burwash had moderate health services expenditures per inmate, \$383, but a high expenditure per staff member, nearly \$18,000.

The training schools (Table 23) showed rather less variability. During the year Cecil Facer School was opened (August 1971) and Project D.A.R.E. was started (June 1971). Trelawney House was

being phased out and has since been closed. Pine Ridge and Grandview, which are the reception centres, had the highest health services expenditure, most of it representing professional salaries and fees. The expenditure per student was twice as great at Grandview, attributable to more numerous staff for the same student population - the population/staff ratio for Pine Ridge being nearly twice that of Grandview. This is only partly due to the fact that Dr. Chamberlain, the consulting psychiatrist, has already investigated many of the boys in the Psychiatric Clinic of the Juvenile Court of Toronto. Glendale and Hillcrest spent only half as much as these other schools per staff member, but Glendale spent twice as much as Hillcrest per student.

These contrasts and other evidences of variability in numbers of health personnel and expenditures among institutions and schools in relation to inmate or student population, serve to highlight differences of potential significance to health care and should serve as a point of departure in the development of an adequate and rational system of health services. The Committee believes these statistical studies provide a basis for understanding the extreme and unacceptable variability of health services observed directly by the Committee and the consultants. Direct observations have served to demonstrate striking differences in health care from institution to institution.

### VIII. R E S E A R C H

The effectiveness of the health services - medical, dental, psychiatric, nursing, social and psychological - must be assessed progressively by a built-in plan for prospective evaluation. New or unproved treatment modalities to which health services contribute must be subjected to research employing some form of planned evaluative experimental design. The Committee has been made aware of current and recent studies within the Ministry\* and has discussed research with Ministry officers including, among others, Dr. Surridge, Dr. Norton, Mr. Shoom and Dr. Hutchison. A good deal of interesting and potentially useful work on psychological and social problems has been carried out. However, evidence available to the Committee is minimal to indicate that psychiatric, and/or social, or psychological treatment programs in the Ministry alter for better or worse the natural history of the offenders' behavioural adjustments following discharge or graduation. One exception was the preliminary data provided us concerning the work of Dr. Freund on sexual deviancy. The work in progress at Monteith in collaboration with the Addiction Research Foundation on the treatment of alcoholism has resulted from an evaluative experimental design including random selection with control and treatment groups. The findings should contribute to improved understanding of alcoholism and better treatment within the Ministry. The Committee was advised that a follow-up study of individuals discharged from Vanier Centre for Women is under way in an attempt to assess the efficiency of the therapeutic milieu/community.

\*The Research and Planning Branch provided copies of research reports and lists of current and recent research projects, (including "Research Projects as of April 1972").



Without further understanding of the biological-medical mechanism of violence and disordered behaviour, and of the social and psychological factors, programs for the rehabilitation of offenders cannot escape being empirical and speculative. It follows that ongoing research, both operational and social-psychologic-biologic-medical, is essential and vital to progress.

1. Clinical investigation or human experimentation

Under the circumstances of incarceration of inmates, the Committee places even greater importance on the ethics of experiments involving humans than is the case in civilian life. A fully informed, freely given permission by the individual inmate after the most comprehensive explanation of the risks and potential benefits to be derived from the experimental program should be mandatory. There follows a quotation from the Medical Research Council Grants and Awards Guide, 1972, under the heading "Clinical Investigation", Paragraphs 13, 14 and 15:

"13. The Medical Research Council attaches great importance to the ethical acceptability of experiments involving human subjects. It is recognized that the investigator has a professional responsibility in this respect and that the institution in which the research will be conducted must also make certain that the experiments are conducted in an ethical way. Over and above this, the Medical Research Council examines the ethical considerations as part of its review of each proposal and funds will not be provided unless the protocol is entirely satisfactory in this respect."

"14. The Medical Research Council requires that each clinical investigation project for which funds are sought from the Council be reviewed concerning its acceptability on ethical grounds. The review



is to be carried out by a local institutional committee convened by the Head of the Department in which the proposed research is to be done and will consist of a representative appointed by the Dean or the institutional administrative officer, two individuals knowledgeable in the field of the proposed research but not associated with the proposed project and preferably not from the department in which the project is to be carried out, and one or more individuals who will represent a general point of view. The review committee is to report on form MRC 33 over the signatures of the Head of the Department and the Dean (or the institutional administrative representative) indicating the composition (though not necessarily the names of the members) of the committee and stating its opinion that the proposed research is acceptable from an ethical point of view. It is understood that the applicant should not serve on the Committee nor should he sign on behalf of the department or the faculty. If the committee finds the proposed project unacceptable, the application for a grant should of course not be forwarded to the Council. "

- "15. Forms MRC 33 are required in connection with all new research proposals but need be submitted only every third year thereafter. A letter from the investigator stating that the protocol of the experiment has not changed must accompany requests for renewal of grants in the intervening years. "

No documentation was found in the Ministry indicating that -

- (i) inmates gave written consent, after full and complete explanation, of their willingness to participate as subjects in experimental programs conducted by medical doctors, psychologists or social workers;
- (ii) projects involving human experimentation had received review and approval by a formal group, by the Superintendent, and by the Director(s) of Medical Services, of Social Work, or of Psychology, according to the research worker(s) involved.

However, the Committee understands that the approval of the Director of Research and Executive Director of Professional Services, has been necessary for a research project to be undertaken in the Ministry.

Appendix E is an admirable discussion of ethics involved in human experimentation as developed in 1964 by a committee chaired by Dr. George Lavery.

Additionally, the question arises as to whether or not an inmate is able to give freely permission to act as a subject for clinical investigation that does not infringe upon his civil rights. He may feel that a threat is implied if he does not give his consent. The Committee concludes that seeking permission by an inmate to participate as a subject in a clinical investigation should be preceded by the most careful consideration of the research program.

All health sciences research projects conducted by doctors, dentists, nurses, social workers, psychologists or any other allied health professional involving human experimentation on inmates, or students, or staff, must be formally approved in advance by the individuals and groups responsible for the health, welfare and custody of inmate or student research subject; e. g. by the superintendent of the institution involved; by the Ministry consultant in the appropriate field; and by the proposed Ministry Research Council (p. 203). This procedure must be followed whether the project is being conducted by Ministry staff full-time or part-time, or by an external agency.

## 2. Ministry Health Research Council

A Ministry Health Research Council should be created, chaired by a distinguished research worker occupying a responsible position related to research in the health sciences in university, university affiliated hospital or institute. The chairman should be the Research member of the Health Services Advisory Board.

Research, scientific and operational research, and performance assessment of the health services is essential. The scope of the research program should be approved by the Ministry Research Council, which should set up a project review mechanism. Evaluation is needed of the effectiveness of psychotherapy, individual or group, provided by psychiatrist or allied health professional. The evaluation of the contribution of physician, psychiatrist, nurse practitioner, psychiatric nurse, specialized social worker and clinical psychologist to the therapeutic milieu/community, is essential if rehabilitation and treatment program development are to rest on a foundation of facts rather than the eloquence of individual advocacy.

Substantial financial support is needed of research by the Ministry into the health sciences with particular reference to the biomedical and psychiatric studies of behavioural disorders and violence; and the need for advances in psychologic, biochemical and pharmacologic treatment is substantial and full of potential. The health research budget of the Ministry should be spent on research

in health sciences and should not include the costs of regular on-going follow-up studies of the outcome of the total Ministry rehabilitation and treatment program, e. g. incidence of parole violation; recidivism. Financial support of research should not reduce the health services budget. Because of the lead time necessary to develop health sciences research projects of quality, \$100,000 is recommended for the Ministry health research budget 1973-74; \$200,000 for 1974-75; \$300,000 for 1975-76 and increasing to \$500,000 by 1977-78. The Committee envisages that a major portion of the research will be contracted for with universities and hospitals with which Ministry institutions should be affiliated.

All health services research projects, scientific and operational, developed in the Ministry by full-time or part-time staff and requiring financial support from Ministry funds, should receive it only upon the recommendation of the Ministry Research Council. Ministry research grants to external agencies should also require this recommendation. It should be recognized that well-planned worthwhile research projects pertaining to correctional services can be expected to receive financial support from other Federal and Provincial research grants. Such projects should also have prior approval by the Ministry Health Research Council.

The Ministry Research Council should be an independent executive committee making recommendations to the Executive Director of Health Services; it should be chaired by the Ministry

Consultant in Research. One area of special responsibility of the chairman is to advise regarding membership on the Ministry Health Research Council:

Consultant in Research - Chairman;

A member of the Ministry staff;

A member appointed by the Minister upon the recommendation(s) of a university named by the Minister;

A member appointed by the Minister upon the recommendation(s) of the Minister of Health;

A member appointed by the Minister upon the recommendation(s) of the Ontario Mental Health Foundation;

A member appointed by the Minister upon the recommendation(s) of the Addiction Research Foundation.

The regular term of appointment should be for five years, renewable by agreement and with the approval of the Minister for an additional term of three years.



IX. INTER-MINISTRY COOPERATION AND STUDIES

(Ministries of Correctional Services, Health,  
Community and Social Services and Attorney General)

1. Ministry interfaces: Health and Correctional Services

Mental health

Mental retardates - The long-term health care of these individuals stems from the Ministry of Health. Close-knit integration of the health services of the Ministry and of the Ministry of Health should be developed. Students/wards, upon "graduation" or before, should move smoothly and directly into the system of the Ministry of Health.

Psychiatrically ill children - Reference has been made to the needs of these children, often seriously disturbed, depressed and schizoid. The isolated psychiatric facilities of the Ministry are profoundly inadequate to their needs. The Ministry of Health, judging from reports from training schools, commonly cannot accept these children for treatment because of lack of facilities and staff. The Government of Ontario should review the confidential report concerning Emotionally Disturbed Children in Ontario (March 1966 - A Report to the Minister of Health - Coordinating Minister) with a view to allocating responsibility for the development of health services for the care of mentally ill students/wards in the framework of the Ministries of Correctional Services and Health. The care of psychiatrically ill students/wards requires the support and involvement of the Ministry of Health.

The Mental Health Division of the Ministry of Health operates a province-wide system of mental health clinics and Psychiatric Hospitals. This Ministry (Correctional Services) is operating a 24-bed Neuro-Psychiatric Clinic and cell block at Guelph and a 10-bed psychiatric cell block at the Toronto (Don) Jail. Development of policies to produce the closest possible integration between the two Ministries should be undertaken with the objectives of satisfying the legal requirements of custody and of providing the best possible mental health and other medical care.

#### Public Health inspections

It is the duty of the Ministry of Health and it has power "...to inspect all correctional institutions...and ensure that such institutions are kept in a proper sanitary condition and that this Act and the regulations are complied with." (The Public Health Act, R.S.O. 1970, Chapter 377, Section 4(e)).

Policies for the public health inspection program were drawn up by senior officials of the Departments of Health and Correctional Services and the program was launched in December, 1969.

Fifty inspections made during the year ending March 31, 1972, fell well short of the proposed quarterly frequency of inspection. In the three months following March 31, 1972, 44 inspections have been made. The Committee understands that the desirable frequency of inspection cannot be attained with the existing staff and present priorities of the Ministry of Health. The recommendation is that inter-Ministry consultation between Health and Correctional Services

should lead to a firm policy allocating responsibility and resources to ensure the planned quarterly inspection of Correctional Services institutions.

Appendix F, attached, is a report regarding inspection of a correctional institution. In the opinion of the Committee the excellence of this report supports the recommendation that quarterly inspections, should be continued.

#### Venereal Disease

In this period of rapid increase of the incidence of venereal disease, new emphasis should be developed on health procedures in the Ministry institutions.

The incidence of reported cases of gonorrhoea in Ontario increased from 84.8 to 112.6 cases per 100,000 population between 1969 and 1971, and the true figures are probably 3 to 4 times the number reported. 55% of these cases occur in the 20-29 age group; an additional 20% are in the 15-19 age group.\* Of persons convicted in Ontario courts in 1971, 24% were under 21 and 51% under 30 (Table 2, Page 23). Of individuals admitted to adult correctional institutions (excluding jails) in 1970-71, 58% were under 30 (Table 8, Page 50).

Obviously, by age and by the nature of inmates/wards' behavioural problems, they would appear to be a high risk group.

Under the circumstances of custody in overcrowded jails with multiple occupancy of cells, the treatment and elimination of communicable disease - venereal disease - is regarded as mandatory by the Committee and as early as possible following admission.

\*Incidence of Syphilis and Gonorrhoea in Canada 1971 R. Bulletin Vol. 3, No. 9, pp 162-165 (Oct. 1972), Health Protection Branch, Dept. of National Health and Welfare, Ottawa.

The recommendation is made that proper screening examinations must be undertaken to EXCLUDE the presence of venereal disease in the population of jails, correctional centres and training schools; that appropriate examinations must be carried out unless the physician and/or nurse practitioner are satisfied that the inmate or student is NOT suffering from venereal disease.

Effective follow-up of treatment within the jail, correctional centre or training school, should be the responsibility of the health services of the Ministry and reports forwarded to the Ministry of Health. The contacts outside the Ministry institution should be identified and followed up by the Ministry of Health. On discharge the patient should be transferred to the care of a physician who is advised of the illness or be followed up by the Ministry of Health.

The Ministry of Correctional Services operates on a province-wide basis involving transfer of inmates regardless of municipal boundaries. The responsibility for venereal disease control belongs to the local Medical Officer of Health. The extent to which the program of venereal disease control is carried out varies from municipality to municipality. The follow-up of contacts and discharged patient/inmates will vary accordingly.

The Ministries of Health and Correctional Services should develop a province-wide uniformly effective system of venereal disease control for the Ministry of Correctional Services. Information based on province-wide screening for venereal disease in Ministry institutions should be developed in support of venereal disease control by the Ministry of Health.

Radiation hazard and safety precautions

A system of inspection of x-ray equipment should be developed by the Ministry and the Radiation Protection Service of the Ministry of Health. The Committee proposes for consideration by the Ministries -

- (i) that x-ray examinations should be carried out only by, or under the supervision of, a radiologist and/or qualified radiographer;
- (ii) that only specially trained correctional officers should be permitted to carry out specified x-ray examinations; and
- (iii) that the usefulness of x-ray equipment in Ministry institutions is questionable, save in large jails and large correctional centres; generally, x-ray examinations should be carried out using local hospitals or local health units.

2. Inter-Ministry studies and health responsibilities

The Ministry of Correctional Services, in the course of carrying out its broad functions related to legal custody, faces many needs paralleling those served by the Ministries of Health, Education, and of Community and Social Services and of the Attorney General.

This Committee recommends:

a) for immediate development -

- (i) a ministerially directed interdepartmental study by the Ministry of Health and the Ministry of Correctional Services, in collaboration with the Ministry of the Attorney General, of the care of the mentally ill and retardates who are students/wards, before the courts, or in custody;
- (ii) a study of rehabilitation by the Ministry of Correctional Services in cooperation with the Ministry of Community and Social Services and the Ministry of Health;

and b) for the longer term an interministerial study should be



promptly initiated to establish what health services should be provided by the Ministry of Correctional Services, by the Ministry of Health, by the Ministry of Community and Social Services, and by the Ministry of the Attorney General. The study should include consideration of the extent to which services should be actually housed in the Ministry of Correctional Services while staffed by other Ministries.

The Committee believes Ministerial consideration should be given to the following propositions:

- (i) That the health services of the Ministry of Correctional Services should be a component unit of the one comprehensive health care program for Ontario for which the Ministry of Health is responsible.
- (ii) That the health services program of the Ministry of Correctional Services should bear the same sort of relation to the Ministry of Health as do the Addiction Research Foundation and the Ontario Cancer Treatment and Research Foundation.

The conclusions and recommendations put forward in this report are designed to improve the health services for students/wards and inmates, to contribute to the efforts of wards and inmates to rehabilitate themselves, to advance inter-ministry cooperation, to avoid duplication of health services, and to improve cost benefits.

The needs and responsibilities of the Ministry of Correctional Services pertaining to the health care of wards and inmates should be recognized in the strategic planning of one comprehensive health program for the people of Ontario. Active inter-ministry collaboration, particularly with the Ministry of Health, is needed to achieve the best possible health care for students/wards and adult inmates.

The treatment of the sick patient/inmate or student/ward may involve special custodial measures but the first priority should be the care of the sick child or adult inmate.

## X. CONCLUSIONS AND RECOMMENDATIONS

### 1. Summary of conclusions and recommendations

#### Introduction

In this Report, and particularly in Sections VI to IX, many conclusions and recommendations have been made concerning the system of health care in the correctional institutions and training schools. For convenience in reference and review it seemed worthwhile to collect them here in summary fashion. These conclusions and recommendations should be considered in the light of the purpose of this enquiry - "...to make a broad enquiry into the entire health care system of the Department."

#### General

1. Redevelopment of Ministry health services in a comprehensive fashion must be multidisciplinary and collaborative. (p. 96)
2. All health services provided within a Ministry institution for wards or inmates whether by allied health professional or medical consultant, unless the latter accepts full responsibility, should be in association with one responsible medical officer or a nurse practitioner working under his/her supervision. (p. 131)
3. To assess the effectiveness of the various health services treatment programs in training schools - (a) evaluative experimental design should be employed; (b) wards must be followed up both as wards and adults, without destroying the humanitarian concept of a fresh start as an adult; (c) means must be found to ensure that the health data, medical, social and psychological, accumulated for wards will be readily available in adult life for the benefit of the individual's health care and as well for the courts and correctional institutions. (p. 125)

4. Initial medical screening and assessment of the health status of individuals admitted to jails should be prompt, within three hours, and carried out by the nurse practitioners. (pp. 110, 155)
5. A satisfying professional role should be attainable in the Ministry for physician, nurse, nurse practitioner, dentist and allied health professional staff. They must be able to envisage themselves as first-class professional citizens. (pp. 82, 105)

#### The Governing Colleges

6. So that the public interest may be fully served and protected, the Governing Colleges of the primary health professions (medicine, dentistry and nursing) should concern themselves with health services provided for students in training schools and inmates in adult correctional institutions in the same responsible fashion as they do for the other citizens of Ontario, i.e. College of Physicians and Surgeons of Ontario, College of Nurses of Ontario, and the Royal College of Dental Surgeons of Ontario. (p.100)
7. The Colleges should acknowledge a clear mandate; they must be provided with the financial means to investigate, to the full extent the individual college judges necessary, complaints concerning professional health services in the broad fields of medicine, dentistry and nursing. (p. 100)
8. As colleges or other arrangements are developed for the allied health professions, e.g. under a Health Disciplines Act, they too should have responsibility and concern for the health services activities of their constituent members in the Ministry of Correctional Services. (p. 100)
9. Recommendations are made about the role of a governing college regarding complaints made by students and inmates, (1) lodged through Ministry channels, (2) made to persons outside the Ministry. (p. 101)

#### The Executive Director of Health Services

10. A line of professional responsibility and authority regarding health care services should lead to an Executive Director of Health Services, who will be directly responsible to the Deputy Minister. (pp. 5, 84)

11. An Executive Director of Health Services should be established who will be responsible for: (a) maintaining proper quality of professional comprehensive health care services throughout the Ministry and for their contribution to the Ministry treatment and rehabilitation program; (b) for the executive management of the Ministry system of delivery of health care; (c) for developing and managing the Ministry budget for health services in keeping with government policy, including planned program budgeting; (d) for recommending all appointments to the health services staff upon the recommendation of the appropriate consultant, after consultation with appropriate university and/or hospital and with the concurrence of the superintendent of training school or adult institution. (pp. 84-86, 102)
12. The Executive Director of Health Services should be appointed upon the advice of a broadly based Ministerial committee chaired by the Deputy Minister. (p. 88)
13. Planned Program Budgeting - So that Ministry policy for health services can be implemented successfully, the Committee recommends that the Executive Director of Health Services be responsible for the development and operation, in keeping with Ministry policy, of a planned program budget for the system of health care delivery. (p. 103)

#### Health Services Advisory Board - Consultants

14. A Health Services Advisory Board of Consultants should be established, chaired by the Executive Director of Health Services. (pp. 88, 90)
15. Purpose and functions of the Health Services Advisory Board should be to advise regarding the best possible health services; to provide the setting for professional expertise to bear on problems of health care services; to consider the problems raised by Ministry and by professional staff; to assure the continuing education of health services staff; to advise regarding plans for suitable facilities and equipment; to review all proposals for new treatment services and any new training school or adult institution requiring health services; to advise concerning the need for health personnel and resources throughout the Ministry. (p. 90)
16. Consultants in the health services to the Ministry should be appointed who are widely recognized for their professional attainments and clinical competence. They should hold major part-time appointments for five to eight years. (pp. 90, 91)



### Health Services Advisory Board - Institutional

17. A Health Services Advisory Board (Institutional) is recommended for each training school, adult correctional centre, regional detention centre and large jail. (p. 94)

### Health Services Personnel

18. Ministry guidelines should be developed concerning the minimum establishment on an institutional, regional and Ministry basis for health services personnel (doctors, dentists, nurses, psychiatrists, nurse practitioners, psychometrists, psychologists, specialized social workers (medical, psychiatric), dental hygienists, and auxiliary health personnel, et al). (p. 120)

### Medical officers - physicians and psychiatrists

19. Physicians and psychiatrists serving the Ministry institutions should be retained for sufficient time for them to contribute to the Ministry rehabilitation program, as well as to care for the sick. (p. 132)
20. For a physician to become interested and involved in the total Ministry rehabilitation program requires a commitment of time of not less than three half-days per week plus provision for emergencies. (p. 121)
21. So that the medical officer will maintain his professional associations and standards and avoid taking on a custodial role, he should carry on his practice outside the Ministry. (p. 121)
22. Six half-day sessions per week should be the maximum commitment of a physician serving an adult correctional centre, jail or regional detention centre. (p. 121)
23. For physicians who choose a Ministry career with a view to full-time senior administrative responsibilities, the Ministry should offer full-time professional appointments as civil servants. (p. 122)



Affiliation with university health sciences complex, etc.

24. The Ministry should seek affiliation for training schools and adult institutions of appropriate size and complexity with one university and its health sciences complex, satellite centre or affiliated Ontario Psychiatric Hospital. (p. 98)

25. From the outset, the Ministry should seek affiliation of Oakville Reception and Assessment Centre with the University of Toronto, particularly the Clarke Institute, the Psychiatric Clinic of the Toronto Juvenile Court and the university affiliated Hospital for Sick Children. (pp. 98, 134)

26. At this time it is recommended that the Ministry should seek university affiliation for the following correctional institutions and training schools:

- |                         |   |
|-------------------------|---|
| McMaster University     | - White Oaks Village and Sprucedale           |
| and its Health Sciences | School, Hagersville                           |
| Complex and Thunder     | - Grandview School, Galt                      |
| Bay Satellite Centre    | - Hillcrest School, Guelph                    |
|                         | - Guelph Correctional Centre                  |
|                         | - Hamilton Jail                               |
|                         | - Thunder Bay Jail and Correctional Centre    |
| University of Toronto   | - Pine Ridge School, Bowmanville              |
|                         | - Oakville Reception and Assessment Centre    |
|                         | - Vanier Centre for Women, Brampton           |
|                         | - Brampton Adult Training Centre              |
|                         | - Alex G. Brown Memorial Clinic, Mimico       |
|                         | - Mimico Correctional Centre                  |
|                         | - Toronto (Don) Jail (St. Michael's Hospital) |
|                         | - Central Ontario Reception and Assessment    |
|                         | Centre (Adult) ?? Brampton                    |
| Queen's University      | - Quinte Regional Detention Centre            |
| and its Health Sciences | - Millbrook Correctional Centre               |
| Complex and Sudbury     | - Burwash Correctional Centre                 |
| Satellite Centre        |   |
| Ottawa University       | - Rideau Correctional Centre, Burritts Rapids |
|                         | - Ottawa-Carleton Regional Detention Centre   |
|                         | - St. Joseph's School, Alfred                 |
| University of Western   | - London Jail                                 |
| Ontario                 | - Windsor Jail                                |

27. In each instance financial support of the university health sciences complex is recommended to establish new posts for doctors who will also serve the Ministry. (p. 99)

Health centres, reception and assessment centres,  
regional centres

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28. The Ministry system of health care delivery should be developed on a regional basis. (pp. 128, 135, 138, 141)
29. The health services in the adult institutional or training school health centre should include only the specialized social and psychologic services, collaborating closely with the general social services. (p. 128)
30. The function proposed for a Ministry health centre is outlined on Page 129. (pp. 128, 129)
31. At the Brampton Centre: (a) the Central Ontario Clinic - 100 beds - a comprehensive health reception and assessment centre should be established for first incarcerates and those age 16-18 from Central and Southern Ontario; (b) the Alex G. Brown Memorial Clinic should be allocated 70 beds; (c) 30 beds should be allocated for a special centre for drug abusers (including alcohol) separate from the A. G. Brown Clinic and under separate professional direction. (pp. 136-138)
32. Ministry regional health centres, affiliated with university health sciences complexes and satellite health centres, should provide assessment services corresponding to those of the Central Ontario Clinic. (pp 138-139)
33. Ministry regional reception and assessment centres for children and juveniles should be established. Affiliation should be sought with university health sciences complexes and satellite centres, as well as liaison with juvenile court psychiatric clinics. (pp. 134-135)
34. Assessment for children requires full multiphasic screening. This will require major expansion of diagnostic resources and facilities, and of personnel. This is of special importance for children committed for the first time. (pp. 127, 135)

Ministry health services - part of Ontario health care program

35. The Ministry comprehensive primary care program should be recognized as part of the health care program for the people of Ontario. The Ministry utilizes the resources of the Ministries of Health, of Community and Social Services, of general, children's and special hospitals, and of special agencies. (pp.97,211)

Health records and information system

36. All health services information should be readily available in one problem-oriented comprehensive health record. (p.131)
37. Initially a Health Status Report should be developed for all inmates of jails requiring classification other than those to be transferred to adult correctional centres as primary incarcerates, or age 16-18, via the Central Ontario Clinic or a regional health centre. (p.142)
38. Multiphasic health screening should begin with a minimum of delay at the Central Ontario Clinic and should not be contingent upon electronic data processing. (p.145)
39. Multidisciplinary evaluation of each inmate at the Central Ontario Clinic or regional health centre must lead to an individual Health Status Report for the Classification Board. (p.145)
40. In all Ministry health centres, health records should be problem-oriented, with effective record linkage throughout the Ministry and immediate availability of centrally stored records. (pp.145-6)
41. Investigation should be undertaken of management of information involved in the system of health care delivery throughout the Ministry. (p.149)
42. A Health Status Report for each child should result from the comprehensive multiphasic health examination at the Oakville Reception and Assessment Centre and regional reception and assessment centres. (p.132)
43. The comprehensive health record must be immediately available in the institution to health services staff, accompany the student or inmate upon transfer, be stored in a Ministry headquarters Central Records and Data Processing Centre at discharge or graduation. The health record must be immediately available to any Ministry institution in the event of recidivism, by telephone, telex, facsimile transmission or the like. (pp.145-6)

44. Inmates should be precluded from handling their own or other inmates' health records.. (p.146)
45. The Ministry health information management system must be compatible and linked with the province-wide health information management system. (p.146)
46. The priorities of the Ministry of Health may delay the development of a new system for managing health information, including electronic data processing of health care records and record linkage. In this event, the Ministry of Correctional Services should make an admirable model of reasonable size for a development jointly by the Ministry of Health and the Ministry of Correctional Services. The successful development of record linkage and a Ministry of Correctional Services central records system should facilitate the development by the Ministry of Health of a system of managing information concerning health, when "all health needs will be served by one comprehensive program". (pp.148-9)

(An Implementation Plan for the New Orientation and Structure of the Ministry of Health, August 22, 1972, p.2)

47. The individual health record should reflect the collaborative efforts of the multidisciplinary team. THE BODY OF THE HEALTH SERVICES RECORD MUST BE CONFIDENTIAL TO HEALTH PROFESSIONS: ONLY THE CONCLUSIONS AND RECOMMENDATIONS RELEVANT TO GENERAL MINISTRY TREATMENT AND MANAGEMENT SHOULD BE COMMUNICATED TO THE RESPONSIBLE MINISTRY STAFF. (p.145)

#### Remuneration of health personnel

48. Payment of medical officers (general practitioners, pediatricians and physicians) generally should be on a sessional basis, using initially the mean (average) taxable income of their group as eleven-elevenths (11/11ths). Payment for one half-day session per week throughout the year would equal one-eleventh (1/11th) of the average income of their group in Ontario projected to the current year. (p.106)
49. Payment of psychiatrists and other medical specialists on a sessional basis should follow the same principles of remuneration. (p.107)
50. Where payment of physicians is by fee-for-service, the tariff accepted by O.H.I.P. should be used by the Ministry. (p.107)

51. Dental services paid for either by salary, by session, or by fee-for-service must allow the individual to earn an income commensurate with the average income of civilian practice. (p.108)
52. Ministry consultants must be paid at a rate commensurate with the rewards of civilian practice. The upper level of the third quartile of their respective professional groups in Ontario is proposed. (p.104)
53. The nurse practitioner should be paid about \$1,800/\$2,000 a year more than the most highly rated nurse, starting in charge of a Ministry health centre, e.g. Mimico, Guelph, Burwash, the Toronto (Don) Jail. (p.108)

#### Effective use of health manpower

54. Effective use of health manpower requires that special knowledge and skills should be fully utilized. (p.150)
55. Certain existing critical deficiencies of staff, varying from institution to institution, require major remedial efforts. (p.122)
56. The duties of auxiliary personnel and specialized allied health professionals should be redefined and numbers expanded (p.150)
57. Expanded clerical and secretarial assistance (non-inmates) should be provided in the health centres of adult correctional centres. (p.122)

#### Nurse Practitioner

58. Nurses and nurse practitioners must assume new responsibilities and play an expanded role in the system of delivery of health care in all types of Ministry institutions. (p.151)
59. Nurse practitioners should undertake the same functions in the Ministry which the Boudreau Committee judges appropriate in civilian centres. (N.B. - Assessment of health status; determination of need for medical, nursing or other intervention; initiation of treatment or referral as may be appropriate; supervision of the health care of well children.) (pp.152, 153)
60. At this time, nurse practitioners in the Ministry should work under the supervision of the physician. (p.153-4)



61. The Ministry should provide financial support for the training of nurse practitioners on a "return-of-service" basis. (p.155)
62. The nurse practitioner, working under the supervision of the physician, should be established as competent to determine if an inmate is fit for transfer. (p.155-6)
63. In jails, correctional centres, and training schools, the nurse practitioner should assume her new role in health care at the earliest possible date. (pp.151,156)
64. The nurse practitioner should assess the health of students and inmates admitted, conduct sick parades and establish fitness for transfer. She should be responsible to the chief medical officer for the administration of the health centre. (pp. 155, 156)
65. Each adult training centre should have available the services of a nurse practitioner on a regular sessional basis and for emergency visits. (pp. 123, 157)
66. Nurse practitioners: a new civil service classification is recommended. (p. 108)

#### Hospital officers

67. A new role and more advanced training are proposed for hospital officers - correctional officers. They should receive extra pay on demonstration of competence. (pp. 157-8)

#### Psychiatric services - Adult

68. General physicians, nurse practitioners, nurses and psychiatric nurses in adult institutions (and training schools), should be specially educated in psychology and psychiatry. (p. 131)
69. Psychiatric consulting services should be expanded in a number of jails, the regional detention centres and adult correctional centres. (pp. 159, 172)
70. A substantial increase should be made in the provision of psychiatric services for adult ambulatory patients. (p.169)
71. Medium security psychiatric patients should be transferred to regional psychiatric units just as maximum security psychiatric patients are transferred to Oak Ridges, Penetanguishene. (p. 170)

72. Expanded medium security psychiatric hospital facilities should be provided for sick inmates of jails and adult correctional centres. The development of medium security regional psychiatric units should take place within university affiliated Ontario psychiatric hospitals and other affiliated psychiatric facilities, e.g. Clarke Institute, Royal Ottawa Hospital. (pp. 160, 172)
73. Regional psychiatric units should be planned jointly by the Ministry of Correctional Services, the Ministry of Health, the hospital concerned and the university regional health sciences complex. (p. 172)
74. Encouragement to care for these medium security patient/inmates should be offered in the form of the necessary staff and facilities to certain psychiatric hospital directors (Queen Street and Penetanguishene Mental Health Centres and the Hamilton, Kingston and London Psychiatric Hospitals, the Clarke Institute and the Royal Ottawa Hospital), having regard to priorities based on regional needs. (p. 172)

#### Psychiatric services - Students/wards

75. Increased psychiatric consulting services for students/wards should be provided on a year-round basis, eliminating large seasonal gaps. (pp. 123, 166)
76. The Ministry should support in every way the development of strategically placed psychiatric units for children and adolescents in university affiliated Ontario Psychiatric Hospitals and psychiatric facilities, and children's hospitals. Resources must be found to establish or expand psychiatric units which will care for mentally ill students/wards from training schools. (p. 166)
77. Decisions regarding external security and locked wards for a child sick enough to transfer to psychiatric hospital should remain the responsibility of the medical director and his staff, with full consideration of legal responsibilities. (p. 166)

#### Guelph Neuro-Psychiatric Clinic

78. As new consulting services and hospital regional psychiatric units are developed, the Guelph Neuro-Psychiatric Clinic should be phased out; no new Ministry neuro-psychiatric units should be established. (pp. 170, 171)

79. The Guelph Neuro-Psychiatric Clinic should become the diagnostic psychiatric division of the Central Ontario Clinic - the health reception and assessment centre proposed for Brampton. (pp. 171, 176)

#### Alex G. Brown Memorial Clinic

80. The primary goal of the Clinic should be the development and dissemination of knowledge about the care of wards and inmates who have problems related to drug abuse (including alcohol). (p. 178)
81. The Clinic should not increase in size or expand the range of treatment services until critical evaluation of current "treatment" methods has been accomplished. The collaboration of the Addiction Research Foundation should be sought in planning such research. (p.179)
82. The responsible director of treatment services (not the superintendent) in the A.G. Brown Clinic should be a licensed and specially qualified physician. (p. 179)
83. In the Clinic, the role and professional responsibilities of the treatment (non-medical) team manager and his non-medical professional team colleagues, and the physician on the team, if there is one, should be defined and agreed upon. (p.179)
84. The Committee recommends that the health of an individual in custody and under group or individual psychotherapy, often intense and stressful, should be the identified responsibility of an individual physician, or nurse practitioner with appropriate psychiatric training working under the supervision of the physician. (p.180)
85. Inmates for whom transfer to the A.G. Brown Clinic is proposed should have a full health examination and psychiatric consultation and assessment before transfer, including admission to a regional psychiatric unit, if necessary, by the psychiatric consultant. (p. 179)

#### Psychiatric staff

86. The Committee recommends the following as measures necessary to expand the psychiatric staff and consulting psychiatric services to a level of effectiveness acceptable to the Ministry:

- (i) Financial educational grants for psychiatrists on a return-of-service basis;
- (ii) Sessional indemnities and full-time salaries commensurate with the returns of private consulting practice under O.H. I.P.;
- (iii) The professional support of medical officers and psychiatrists by helpful Ministry consultants. (p.180)

#### Alcoholism and drug dependence

87. Provision should be made for admission of complicated cases of alcoholism to general hospitals from jails and jail lock-ups, by the Ministry and the Ministry of Health. (p.182)
88. The Committee generally endorses and supports recommendations 1-14 developed by Dr. W. E. Boothroyd in Appendix D, and places additional emphasis on:
- (i) The involvement of members of the local community at large in treatment programs, e.g. A.A.;
  - (ii) The continuing education of all Ministry staff with regard to wards and inmates who have problems related to drugs (alcohol);
  - (iii) The fullest possible utilization by the Ministry of the resources of the Addiction Research Foundation. (pp.182-3)

#### Dispensing and administration of drugs

89. Recommendations are made with regard to the dispensing and administration of narcotics and controlled drugs and household drugs. (pp.183-184)

#### Dental care

90. The summary of recommendations developed by Dr. D.W. Lewis, consultant regarding dental care services in the Ministry, Appendix C, is endorsed. Added emphasis should be placed on:

- (i) Clarification of Ministry dental treatment guidelines;
- (ii) Correction of existing anomalies of dentist supply among Ministry institutions;
- (iii) Full use of dental auxiliaries;
- (iv) Revision of existing dental facilities in regional detention centres and updating of future plans for dental facilities. (pp.185,186)

#### Jails and regional detention centres

- 91. On grounds of health, elimination of overcrowding in jails should be given high priority. (p. 111)
- 92. The health services branch of the Ministry should be involved immediately in plans for modification of the facilities in health centres of existing institutions and in planning new Ministry institutions and schools. (p. 117)
- 93. A proposed health services staff for regional detention centres is put forward. (p. 117)
- 94. The recommendation is made that operation of the Ottawa-Carleton and Quinte Centres should be test model or pilot projects utilizing prospective planned systematic operational research. (p. 118)
- 95. Physical facilities for sick parade should ensure professional privacy and the security of professional staff. (p. 187)
- 96. In Ministry institutions, appropriate examination to exclude venereal disease must be carried out unless, in the opinion of the physician and/or nurse practitioner, the inmate or student is not suffering from venereal disease. (p. 208)
- 97. Small jails in small towns should employ a part-time nurse practitioner and part-time physician. (p. 111)
- 98. Medium jails should have initially a half-time nurse practitioner - the equivalent of five sessions a week. (p. 112)
- 99. Larger jails should be provided with a nurse practitioner on the day and evening shifts. (p. 113)



Toronto (Don) Jail

100. In the Toronto (Don) Jail, a full-time nurse practitioner service should be a new, additional and major component of the multi-disciplinary health services team. (pp. 114-5)
101. Unifying professional leadership should be provided for the nursing services in the Toronto (Don) Jail. (p. 115)
102. Immediate development of a new health centre, including psychiatric facilities, should be undertaken for the Toronto (Don) Jail. (p. 115)
103. This new health centre (recommendation 102) in addition to ambulatory patient facilities, should include the following: General medical infirmary beds; medium security psychiatric beds until a regional psychiatric unit is available in a hospital; a maximum security psychiatric unit for temporary holding purposes; pharmacy resources for storing and dispensing drugs. (p. 115)
104. The new health centre for the Toronto (Don) Jail should not be postponed for the years needed to plan and build new regional detention centres in Toronto. (p. 116)
105. The psychiatric staff serving the Toronto (Don ) Jail should undergo major expansion. (p. 116)

Adult institutions (excluding jails)

106. Millbrook - Recommendations are made regarding immediate expansion of health services staff. Special financial support should be provided for Queen's University, the Kingston Psychiatric Hospital and Millbrook in order to obtain staff. (pp. 161-2)
107. Burwash - Redevelopment of administrative and professional health services roles should be undertaken, with particular regard to the "medical" cell block. Psychiatric and psychological staff should be sought through financial support of joint appointments in Sudbury (and the developing Queen's satellite health centre) and at Burwash. (pp. 162, 163)
108. The pressing needs of Burwash, Millbrook and Rideau for psychiatric consulting services and ambulatory treatment, should be largely met by visiting psychiatrists. (p. 170)

109. Vanier - Clear lines of responsibility for the health of inmates should exist. Allied health professionals conducting group therapy should work in association with a physician directly or through a nurse practitioner with special psychiatric training. The health of each inmate should be the identified responsibility of the nurse practitioner and physician, or physician. Responsibility for the quality and scope of health services should not be accepted by a physician, nurse, social worker or psychologist employed by the Ministry in an administrative capacity, e.g. superintendent or deputy superintendent. (p.164)

#### Training schools

110. A specialized adolescent obstetrical and gynaecological consulting service should be developed. (p.123)
111. Additional education resources, people and material, concerning the growth and development of sexuality and contraception should be more readily available to doctors and nurses for the benefit of students/wards. (p.124)
112. Each student/ward should have continuing medical and health care arranged with his own doctor or a clinic prior to graduation and leaving the school. Physician or nurse must ensure that the results of the comprehensive health investigation are passed on to family, physician or clinic prior to graduation and discharge. (p.126)
113. Reconsideration should be given to the expansion of the Oakville Reception and Assessment Centre health facilities, which appear inadequate. (p.135)

#### Research and human experimentation

114. A fully informed, freely given, permission by the individual inmate subject must be mandatory, and after the most comprehensive explanation of the risks and potential benefits to be derived from the experimental program. (p.200)
115. The Committee recommends that seeking permission by an inmate to participate as a subject in a clinical investigation should be preceded by the most careful consideration of the research program. (p.202)

116. All health sciences research projects conducted by doctors, dentists, nurses, social workers, psychologists or any other allied health professional, involving human experimentation, must be formally approved in advance by the individuals and groups responsible for research and for the health, welfare and custody of inmates. (p.202)
117. A Ministry Research Council should be created, chaired by a distinguished research worker occupying a responsible position related to the health sciences in university, affiliated university hospital or institute. The Council should be an independent executive committee, making recommendations to the Executive Director of Health Services. (p.203)
118. The Ministry should provide financial support for research into the biological, genetic, medical, pharmacologic, psychiatric, psychologic and social aspects of disordered behaviour and paroxysmal violence. (p.203)
119. The following recommendations are made for minimum financial support:
- |         |           |         |
|---------|-----------|---------|
| 1973-74 | \$100,000 |         |
| 1974-75 | 200,000   |         |
| 1975-76 | 300,000   |         |
| 1976-77 | 400,000   |         |
| 1977-78 | 500,000   | (p.204) |
120. All research funds should be awarded only upon the recommendation of the Ministry Research Council. (p.204)

Inter-Ministry cooperation

121. Close liaison between the psychiatric clinics of the juvenile courts and Ministry reception and assessment centres should eliminate duplication of clinical facilities. Repetitious examinations of children and juveniles should be avoided both for the sake of the student and because of expense. (pp.132-136, 206, 210-211)
122. Integration and avoidance of duplication of Ministry reception and assessment centres and psychiatric clinics should be the subject of urgent inter-Ministry consultation and planning. (pp.136-138, 207, 210-211)
123. Students/wards who are mental retardates, upon graduation or before, should move into the system of the Ministry of Health. The care of psychiatrically ill students/wards requires the support and involvement of the Ministry of Health. (p.206)

124. The Government of Ontario should review the availability of facilities for treating emotionally disturbed children who are students/wards of the Ministry. (March 1966 - A Report to the Minister of Health - Coordinating Minister). (p.206)
125. Development of policies to produce the closest possible integration between the Ministry of Health and the Ministry of Correctional Services should be undertaken with the objectives of satisfying the legal requirements of custody and of providing the best possible mental health and other medical care. (p.207)
126. Inter-Ministry consultation between Health and Correctional Services should lead to a policy allocating responsibility and resources to ensure the planned quarterly inspection of Correctional Services' institutions under the Public Health Act. (pp.207, 208)
127. The Ministries of Health and Correctional Services should cooperatively develop a province-wide, uniform, effective system of venereal disease control for the Ministry of Correctional Services, in support of venereal disease control in the Province of Ontario by the Ministry of Health. (p.208)
128. A system of inspection of x-ray equipment should be developed by the Ministry of Correctional Services and the Radiation Protection Service of the Ministry of Health. (pp.208-9)
129. X-ray examinations should be carried out only under the supervision of a radiologist or radiographer, and only by specially trained correctional officers. Generally, x-ray examinations should be carried out using local hospitals or health units, except in large institutions. (pp.208-9)

#### Inter-Ministry studies

130. The Committee recommends:

##### A. For immediate development -

- (i) a ministerially directed interdepartmental study by the Ministry of Health and the Ministry of Correctional Services, in collaboration with the Ministry of the Attorney General, of the care of the mentally ill and retardates who are students/wards, before the courts, or in custody;

- (ii) a study of rehabilitation by the Ministry of Correctional Services in cooperation with the Ministry of Community and Social Services and the Ministry of Health

B. For the longer term - an inter-ministerial study should be promptly initiated to establish what health services should be provided by the Ministry of Correctional Services, by the Ministry of Health, by the Ministry of Community and Social Services, and by the Ministry of the Attorney General. The study should include consideration of the extent to which services should be actually housed in the Ministry of Correctional Services while staffed by other Ministries.

(p.210)



2. Review of conclusions and recommendations  
in relation to study objectives

Critical review of the preceding "Conclusions and Recommendations" has been carried out in an endeavour to establish whether or not the objectives of this study as defined in the Introduction (I-3, pp.4,5) have been attained. "To establish (I-3(a)) whether or not - (i) the system of health care delivery may reasonably be expected to provide decent, adequate and effective health services for wards in training schools and elsewhere, and inmates in adult institutions."

The Committee has not examined the health services of wards outside training schools, in foster homes or group homes; a deficiency of this enquiry.

Expressed in the simplest fashion, the existing system of health care delivery in adult correctional institutions, jails and training schools consists of:

- (i) operation by the Ministry of ambulatory patient care with limited diagnostic facilities and of two special clinics and a 10-bed Don Jail psychiatric unit;
- (ii) provision by the Ministry of Health and the hospitals of Ontario with their professional staff of the remainder of the health care program.

While it is difficult to generalize about any health care system, in the judgment of the Committee the variability of the effectiveness of health services from institution to institution exceeds what can be judged acceptable. The system of health care delivery cannot reasonably be expected to provide Ministry-wide decent, adequate

and effective health services. Most simply stated, the fact is that there is no system of health care delivery. Health services are provided to meet the health needs almost on an institution to institution basis. This is not to say, for example, that decent, effective, general medical care is lacking in training schools and in various adult correctional centres. The system of health care delivery encompasses many areas, e.g. psychiatric consulting services, psychiatric hospital care for sick children and sick adult inmates, public health services, initial comprehensive multiphasic health screening (N.B. venereal disease) for children and adults, the contribution of health services to Ministry classification and rehabilitation programs, etc.

In the absence of a system of health care the recommendations of the Report have as the primary objective the establishment of such a system (I-3(b)). New Ministry-wide policy and organization are necessary for the health services. A Ministry plan of redevelopment is needed to ensure enduring improvement of Ministry health services.

The recommendations of the Report have been directed, secondarily, to meet the observed deficiencies in the present health services. These recommendations, reflecting the observations and judgments of the Committee, are designed for the consideration of the Minister, the proposed Executive Director of Health Services and Ministry health services consultants.

With respect to rehabilitation (I-3(a)(ii)), the health services do not make either a maximum or appropriate contribution to students

and adult inmates in their efforts to rehabilitate themselves.

Concerning research (I-3(a)(iii)) in the health sciences, there are at present no research facilities for prospective evaluation for health care services; recommendations have been made to meet this deficiency.

### 3. Prerequisites for redevelopment of the health care system

The Committee judges the redevelopment of the Ministry-wide system of health care delivery to be dependent upon the following:

- (1) The creation of the Executive Director of Health Services and Health Services Advisory Board of Consultants.
- (2) The development of a Ministry policy guiding the system of health care delivery.
- (3) The recognition and development of the role of the nurse and nurse practitioner.
- (4) Establishment as a fact that health services will be provided on a fully professional, confidential basis by health professionals (doctors, nurses, dentists, psychologists and specialized social workers).
- (5) The continuing education of the health services professionals in their own discipline and in the special psychiatric problems of correctional services.
- (6) Affiliation of appropriate Ministry institutions, much as Ontario Psychiatric Hospitals are affiliated, with universities and health sciences complexes.\*

\* Since this Report was written, the Association of American Medical Colleges, Division of Operational Studies, has published a Datagram, "The Medical College and Prison Health Care". Journal of Medical Education, Vol. 47, pp. 831-832. October 1972. (Appendix H)

- (7) The development of research in the health sciences into disordered behaviour and violence.
- (8) The governing colleges of the health professions should concern themselves with health services for wards and inmates as they do for other citizens of Ontario.
- (9) A satisfying professional role should be attainable in the Ministry for physician, nurse, nurse practitioner, dentist and allied health professional staff.
- (10) Payment for professional services by salary, by session or by fee-for-service must allow the individual to earn an income commensurate with the returns of civilian practice. Additional consideration must be given to the professional isolation associated with Ministry practice.
- (11) An inter-ministerial study should be promptly initiated to establish what health services should be provided by the Ministry of Correctional Services, by the Ministry of Health, by the Ministry of Community and Social Services and by the Ministry of the Attorney General.
- (12) The health services must be multidisciplinary, collaborative and comprehensive to include the biological-medical, psychiatric, nursing, dental, pharmacological, psychological and social approaches to sickness, to behavioural disorders and to rehabilitation.

COPY OF AN ORDER-IN-COUNCIL APPROVED BY HIS HONOUR THE  
LIEUTENANT GOVERNOR, DATED THE 26TH DAY OF JANURY, A.D. 1972

OC-390/72

The Committee of Council have had under consideration the report of the Honourable the Minister of Correctional Services, dated January 25th, 1972, wherein he states that,

WHEREAS a Coroner's Jury inquiring into the death of a Mr. Stephen Getson recommended that an inquiry be instituted to investigate the present system of medical examination and treatment in Correctional Institutions;

The Honourable the Minister of Correctional Services recommends that Dr. Harry Botterell be appointed to examine the adequacy and effectiveness of the present system of medical examinations and treatment in Correctional Institutions in Ontario.

The Honourable the Minister of Correctional Services further recommends that Dr. Harry Botterell be paid a per diem allowance of One Hundred and Fifty Dollars (\$150.00) plus reasonable travelling expenses that may be incurred.

The Committee of Council concur in the recommendations of the Honourable the Minister of Correctional Services and advise that the same be acted on.

Certified,

(Signed) J.J. Young  
Clerk, Executive Council.



COPY OF LETTER FROM THE MINISTER TO DR. BOTTERELL

January 28, 1972.

Dr. E. Harry Botterell,  
2 Lakeshore Blvd.,  
Kingston, Ontario.

Dear Dr. Botterell:

On January 7, 1972, a Coroner's Jury inquiring into the death of a man who had died while an inmate of the Toronto Jail recommended to the Coroner:

"that a formal inquiry be instituted to investigate the adequacy and effectiveness of the present system of medical examination and treatment in Correctional Institutions".

On January 18, 1972, I wrote to the College of Physicians and Surgeons of Ontario requesting the College to recommend a physician who I could appoint to be a committee of one to conduct this inquiry.

On January 24, 1972, the College recommended you for this inquiry and you have since indicated to me your willingness to accept the appointment.

I am, of course, delighted that you are prepared to give us your time and the benefit of your extremely great experience and talent. I wish you to know that I am most anxious to have this inquiry conducted as soon as possible and I would stress that I do not wish you to feel at all constrained by the limitations of the Jury's recommendation; rather I would like you to make a broad enquiry into the entire health

Dr. E. Harry Botterell.

Page 2.

care system of the Department. In doing so you may be assured of complete co-operation and assistance from, not only our Director of Medical Services, but also from other personnel within the Department who you feel can be of assistance to you.

In my view this is a most important inquiry, at the close of which I would appreciate a report on your findings and recommendations.

Thank you again for accepting this important undertaking.

Yours sincerely,

(Signed)

C. J. S. Apps,  
Minister

COPY OF NEWS RELEASE DATED 31ST JANUARY, 1972

NEWS RELEASE	ONTARIO DEPARTMENT OF CORRECTIONAL SERVICES Honourable C.J.S. Apps, Minister L.R. Hackl, Deputy Minister
Release: 31/1/72	For further information: D.W. Kerr, Director Information Branch (416)365-4321

COMMITTEE OF ONE APPOINTED TO ENQUIRE INTO  
DEPARTMENT'S HEALTH CARE SYSTEM

Dr. E.H. Botterell, O.B.E., M.D., M.S., former Dean of Medicine and Vice-Principal of Health Sciences of Queen's University, has been appointed as a committee of one to enquire into "the adequacy and effectiveness of the present system of medical examination and treatment in Ontario correctional institutions".

Following the inquest into the death of Mr. Stephen Getson, Correctional Services Minister, C.J.S. Apps, announced that his Department would implement the Coroner's Jury recommendation that such an enquiry be conducted. Subsequently Mr. Apps requested that the College of Physicians and Surgeons of Ontario recommend a physician to undertake the enquiry. The College recommended Dr. Botterell.

Mr. Apps said today that he is most anxious that Dr. Botterell should make "a broad enquiry into the entire health care system of the Department". The Minister pledged the "fullest cooperation of all staff in assisting Dr. Botterell to obtain all information necessary for

the conduct of a thorough and complete investigation".

Born in Vancouver, Dr. Edmund Henry Botterell graduated in Medicine from the University of Manitoba in 1930 and was appointed a Fellow of the Royal College of Surgeons of Canada in 1937. He received his Master of Surgery from the University of Toronto in 1938.

From 1940 to 1945 he served in the Royal Canadian Army Medical Corps as a Lieutenant-Colonel and was, for three years, Officer-in-Charge of Neurosurgery at Basingstoke, England.

In the immediate post-war years he was a Member of the Department of Surgery at the Toronto General Hospital and the University of Toronto. In 1953 he became Head of the Neurosurgical Division of the Toronto General Hospital and held this position until 1962 when he was appointed Dean of Medicine at Queen's University, Kingston. In addition to serving as Dean of Medicine at Queen's until the fall of 1970, he also held the position there of Vice-Principal of the Health Sciences from 1968 to 1970. Dr. Botterell is currently Special Advisor to the Principal of Queen's University.

The Coroner's Jury also recommended that the documentation and search area of the Toronto Jail "be relocated and redesigned to meet the objectives of a modern correctional institution". Plans for innovations to modernize the facilities in this area of the Jail had been finalized and the work had already commenced when this recommendation was made. Work is continuing on these renovations which are expected to be completed by the end of March, 1972.

COPY OF MEMORANDUM FROM THE DEPUTY MINISTER  
TO ALL SUPERINTENDENTS, 9TH FEBRUARY, 1972

Letterhead of  
DEPARTMENT OF CORRECTIONAL SERVICES

February 9, 1972.

MEMORANDUM TO: Superintendents of all Institutions,  
including Jails and Training Schools.

FROM: The Deputy Minister.

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RE: System of Health Care Delivery in  
the Department.

The Minister has asked Dr. E. Harry Botterell to enquire into the provisions for the delivery of health care services at all levels throughout the Department. These broad terms of reference should be brought to the attention of all medical, nursing and dental personnel, members of allied health professions and paramedical personnel.

Dr. Botterell will be making his own arrangements to visit selected institutions with the secretary of his committee, and as necessary, with a professional consultant. In addition, anyone wishing to bring matters to Dr. Botterell's attention is encouraged to do so by submitting material directly to him, at Queen's University, Kingston, Ontario, or through the Director of Medical Services, the Executive Director, Professional Services Division, or the Executive Director, Institutions Division.

For purposes of the work of this committee, all personnel of the Department are requested and authorized to bring forward to Dr. Botterell information they judge appropriate to this enquiry or information requested by the committee, and to release such information to him.

I am certain that your full cooperation with Dr. Botterell will ensure the development of an effective broad study of health care services.

(Signed)

L.R. Hackl,  
Deputy Minister.

Copies to all Main Office Branch Heads.



INTERVIEWS AND VISITS

a) MAIN OFFICE INTERVIEWS

<u>Person(s) interviewed</u>	<u>Committee and Consultants present</u>
The Minister - The Honourable C.J.S. Apps.....	Dr. Botterell
The Deputy Ministers - Mr. H.L.R. Hackl.....	Dr. Botterell
* Mr. D. Sinclair.....	Dr. Botterell ... Dr. Botterell and Dr. Josie ... Dr. Botterell and Dr. Chalke
Executive Director, Administrative and Financial Services Division - Mr. R.T. J. West.....	Dr. Botterell and Dr. Josie
Administrators: Adult Female Institutions - Mr. G.R. Thompson.....	Dr. Botterell and Dr. Josie
Adult Male Institutions - Dr. H.C. Hutchison.....	Dr. Botterell and Dr. Josie
Jails - Mr. H.S. Cooper.....	Dr. Botterell ... Dr. Botterell and Dr. Josie
Training Schools - Mr. H. Garraway.....	Dr. Botterell ... Dr. Botterell and Dr. Josie
Chief Inspector - Mr. H. Hughes.....	Dr. Botterell ... Dr. Botterell and Dr. Josie
Director, Legal Services - Mr. D.F. Morrison.....	Dr. Botterell ... Dr. Botterell and Dr. Josie
Director, Personnel and Staff Training - Mr. G.H. Carter.....	Dr. Botterell and Dr. Josie

\*Interviewed first as Executive Director, Institutions;  
other officers were, in general, not interviewed in their  
new positions after the re-organization of the Ministry.

INTERVIEWS AND VISITS

APPENDIX 5  
(PAGE 2)

a) MAIN OFFICE INTERVIEWS (Cont'd.)

<u>Person(s) interviewed</u>	<u>Committee and Consultants present</u>
Executive Director, Professional Services -	
Mr. D.J. Penfold.....	Dr. Botterell
Directors of Professional Services:	
Medical Services -	
Dr. N.L. Goodwin.....	Dr. Botterell
	... Dr. Botterell and Dr. Josie
Psychology -	
Dr. W.A. Norton.....	Dr. Botterell
	... Dr. Botterell and Dr. Josie
Chaplaincy Services -	
Rev. Dr. M.S. Flint.....	Dr. Botterell and Dr. Josie
Food Services -	
Mrs. I.E. Beal.....	Dr. Botterell and Dr. Josie
Social Work -	
Mr. S. Shoom.....	Dr. Botterell
After-care Services -	
Mr. D.C. Mason.....	Dr. Botterell
	... Dr. Botterell and Dr. Josie
Research -	
Dr. C.T. Surridge.....	Dr. Botterell and Dr. Josie
Coordinator, Community Programs -	
Mr. E.W. Epp.....	Dr. Botterell
Chief Systems and Procedures Officer -	
Mr. R.A. Wills.....	Dr. Botterell and Dr. Josie

INTERVIEWS AND VISITS

APPENDIX 5  
(PAGE 3)

b) VISITS TO CORRECTIONAL CENTRES,  
JAILS AND TRAINING SCHOOLS

Correctional Centres

Committee and Consultants present

* Vanier Centre for Women	Drs. Botterell, Lewis and Chalke and Miss Smale
Burtch Correctional Centre	Dr. Lewis
Burwash Correctional Centre	Drs. Botterell, Chalke and Lewis and Miss Smale
* Guelph Correctional Centre	Drs. Botterell, Josie, Chalke, Lewis and Boothroyd and Miss Smale
* Millbrook Correctional Centre	Drs. Botterell, Chalke and Lewis and Miss Smale
Mimico Correctional Centre	Drs. Botterell and Lewis and Miss Smale
Monteith Correctional Centre	Dr. Boothroyd
Rideau Correctional Centre	Dr. Botterell
Thunder Bay Correctional Centre	Dr. Botterell

Adult Training Centres

Brampton Adult Training Centre	Drs. Botterell, Josie, Lewis and Boothroyd and Miss Smale
Burtch Adult Training Centre	Dr. Chalke
Monteith Adult Training Centre	Dr. Boothroyd
Rideau Adult Training Centre	Dr. Botterell
Thunder Bay Adult Training Centre	Dr. Botterell

Clinics

* Alex G. Brown Memorial Clinic	Drs. Botterell,* Josie, Chalke and Boothroyd and Miss Smale
Guelph Neuro-Psychiatric Clinic	Drs. Botterell and Chalke and Miss Smale

b) VISITS TO CORRECTIONAL CENTRES,  
JAILS AND TRAINING SCHOOLS (CONT'D.)

<u>Training Schools</u>	<u>Committee and Consultants present</u>
<u>Girls</u>	
* Grandview School and Reception and Diagnostic Centre	Drs. Botterell, Josie, Lewis and Chalke and Miss Smale
Kawartha Lakes School	Dr. Botterell
Elmcrest School	Dr. Lewis
<u>Boys</u>	
Brookside School	Drs. Botterell and Lewis
Cecil Facer School	Drs. Botterell and Chalke and Miss Smale
Glendale School	Dr. Lewis
Hillcrest School	Drs. Botterell and Chalke
* Pine Ridge School	Drs. Botterell, Chalke and Boothroyd and Miss Smale
St. John's School	Dr. Lewis and Miss Smale
Sprucedale School and White Oaks Village	Drs. Botterell, Josie, Lewis and Boothroyd and Miss Smale
<u>Jails</u>	
* Toronto	Drs. Botterell, Josie, Chalke and Lewis and Miss Smale
Hamilton	Drs. Botterell and Josie and Miss Smale
Kenora	Drs. Botterell and Boothroyd
Ottawa	Dr. Botterell
Quinte Regional Detention Centre	Drs. Botterell and Lewis and Miss Smale
Sudbury	Drs. Botterell and Chalke
Thunder Bay	Drs. Botterell and Boothroyd
St. Catharines	Drs. Botterell and Josie and Miss Smale
Brampton	Drs. Botterell and Josie and Miss Smale
Cobourg	Dr. Botterell and Miss Smale
Fort Frances	Dr. Botterell
Peterborough	Drs. Botterell and Chalke
Perth	Dr. Botterell
Stratford	Dr. Botterell and Miss Smale

\* Indicates two or more visits.

INTERVIEWS AND VISITS

APPENDIX 5  
(PAGE 5)

c) INTERVIEWS WITH REPRESENTATIVES OF OTHER  
AGENCIES AND ORGANIZATIONS, AND WITH INDIVIDUALS

<u>Dr. John D. Hamilton</u>	)	
Vice President,	)	
Health Sciences.	)	
<u>Dr. Andrew L. Chute</u>	)	University of
Dean of Medicine.	)	Toronto
<u>Professor John L. Edwards</u>	)	
Centre of Criminology.	)	
		Dr. Botterell
		Dr. Botterell
		Drs. Botterell & Josie
<u>Dr. J. F. Mustard</u>		
Dean of Medicine.	McMaster University	Drs. Botterell & Josie and Miss Smale
<u>Dr. Douglas Waugh</u>	)	
Dean of Medicine.	)	
<u>Dr. Robt. J. McCaldon</u>	)	Queen's University
Dept. of Psychiatry.	)	
<u>Dr. Thos. J. Boag</u>	)	
Dept. of Psychiatry.	)	
		Dr. Botterell
<u>Dr. John S. Pratten</u>	Kingston Psychiatric	
Superintendent.	Hospital	Dr. Botterell
<u>Dr. Harry Bain</u>	)	
<u>Dr. Stobo Prichard</u>	)	
<u>Dr. J.D. Bailey</u>	)	
<u>Dr. Quentin Rae-Grant</u>	)	Hospital for Sick
<u>Mr. J.D. Snedden</u>	)	Children
Executive Director.	)	
<u>Mr. L.B. Murray</u>	)	
Assistant Administrator.	)	
		Dr. Botterell
<u>Dr. C. Chamberlain</u>		
Chief, Psychiatric Service	)	
of the Juvenile and	)	
Family Court.	)	Clarke Institute
	)	of Psychiatry
<u>Dr. R.C. Hunter</u>	)	
Psychiatrist-in-Chief.	)	
<u>Dr. C.K. McKnight</u>	)	
Chief, Forensic Division.	)	
		Dr. Botterell
<u>Dr. John Scott</u>	Toronto General	
Chief, E.E.G.	Hospital	Drs. Botterell & Josie
<u>Dr. Barry Boyd</u>	Mental Health Centre,	
Superintendent.	Penetanguishene	Dr. Botterell



INTERVIEWS AND VISITS

APPENDIX 5  
(PAGE 6)

c) INTERVIEWS WITH REPRESENTATIVES OF OTHER AGENCIES AND ORGANIZATIONS, AND WITH INDIVIDUALS (CONT'D)

<u>Mr. E.C. Burton</u> Crown Attorney.	Kenora	Drs. Botterell & Booth
<u>Mr. Len Håkenson</u> Addiction Research Foundation.	Kenora	Drs. Botterell & Booth
<u>Mr. S.W. Martin</u> Deputy Minister.	)	
<u>Dr. G.K. Martin</u> Executive Director, Public Health Division.	) ) Ministry of Health	Drs. Botterell, Josie and Chalke
<u>Dr. H.W. Henderson</u> Executive Director, Mental Health Division.	) ) )	
<u>Dr. Glenn Sawyer</u> General Secretary.	Ontario Medical Association	Drs. Botterell & Josie
<u>Dr. Joseph Dawson</u> Registrar-Secretary.	College of Physicians & Surgeons of Ontario	Drs. Botterell & Josie
<u>Dr. Richard Milne</u> Physician.	Kingston	Dr. Botterell
<u>Mr. Wm. S. McCabe</u> Executive Secretary.	John Howard Society of Kingston	Dr. Botterell
<u>Council of Ontario Faculties of Medicine</u> Dr. A.L. Chute, Chairman.	Toronto	Dr. Botterell
<u>Harvard University</u> Medical School; and Massachusetts General Hospital	Boston, Mass.	Dr. Botterell
<u>Dr. Vernon Marks,</u> Department of Neuro-surgery, Harvard University.	Boston, Mass.	Dr. Botterell
<u>Dr. C.E. Climent</u> Neuro Research Foundation Inc., Massachusetts General Hospital.	Boston, Mass.	Dr. Botterell
<u>Dr. Lawrence Razavi,</u> Dept. of Neuro-surgical Research, Massachusetts General Hospital.	Boston, Mass.	Dr. Botterell

COPY OF LETTER SEEKING VIEWS AND OPINIONS  
OF THE HEALTH SERVICES PERSONNEL

CONFIDENTIAL

April 28, 1972.

As you know from the Deputy Minister's memorandum of February 9th, 1972, I have been asked by the Minister to enquire into the provisions for the delivery of health care services at all levels throughout the Department. I have already obtained from the Deputy Minister, the Director of Medical Services, the Administrators and other officers, most useful information and this is being supplemented by visits to a number of Jails, to Correctional Institutions and to Training Schools.

As you may recall, all medical, nursing and dental personnel and members of allied health professions, were invited to bring relevant matters to my attention. I am obtaining certain basic information about the institutions and schools by means of a questionnaire and health personnel inventory. In addition, it would be most useful for me to have any views or opinions that you think might contribute to improvement of the health care delivery system of the Department.

I would be glad, therefore, if you would use the attached sheet to send me any comments that might be helpful in my enquiry. Such comments and opinions will, of course, be treated as confidential. They will be used in my enquiry only and not as Department documents.

With kind regards and thanks.

Yours sincerely,

(Signed) Harry Botterell

E.H. BOTTERELL, MD.

EHB/sw  
Enclosure

To:

COMMENTS FROM HEALTH SERVICES STAFF

Please express any views and opinions concerning health care delivery that you think might be helpful in improving the system of health care in the Jails, Correctional Institutions or Training Schools of the Department of Correctional Services. Attention is directed particularly to the following topics or areas of possible concern, but please do not feel limited to such matters:

1. Personnel or staff matters (including for example, recruitment and training, professional associations and development, use of aides or associates)

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2. Communications (including for example, lines of authority and channels of communication)

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3. Facilities (including space and equipment)

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4. Other matters:

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Please mark envelope 'Personal and Confidential' and send to me by May 15th, 1972.

Dr. E.H. Botterell,  
c/o Department of Correctional Services,  
434 University Avenue, 4th Floor,  
Toronto 100, Ontario.

April 28, 1972.

COPY OF LETTER SEEKING VIEWS AND OPINIONS OF  
DIRECTORS AND STAFF OF THE PROFESSIONAL SERVICES

This letter addressed to Directors of:

Psychology	Social Work
Chaplaincy Services	Food Services
After-care Services	Education
Recreation Services	Research

May 9, 1972

Dear

As you know from the Deputy Minister's memorandum of February 9th, I have been asked by the Minister to enquire into the provisions for the delivery of health care services at all levels throughout the Ministry. I am obtaining through the Superintendents, certain basic information about the health services in correctional institutions and training schools by means of a questionnaire and health personnel inventory. I have, of course, also obtained valuable information from the Deputy Minister, the Director of Medical Services, the Administrators and other officers of the Ministry and this has been supplemented by visits to a number of jails, correctional institutions and training schools.

In seeking the views of health services professional staff, I referred to personnel matters, communications and facilities, as possible areas of concern, but I invited comments generally on ways of improving the health services. It would be useful for me to have, as well, your views and those of the other Directors of professional services on the general subject of ways of improving the health care system of the Ministry. I would be particularly interested in any comment you might wish to make on the potential value of a multidisciplinary approach to health care services and on the role and contribution of your profession and inter-relationships of the various professional services.

I would appreciate very much your sending me your views and opinions within the next few weeks, preferably by the end of the month. Should you think it advisable or desirable for me to have the views of some or all of the staff under your professional direction, I would be glad to receive them also either incorporated in your own response or sent to me directly.

Your cooperation in this enquiry will be greatly appreciated.

Yours sincerely,

(Signed) Gordon H. Josie

for E.H. BOTTERELL, M.D.

GHJ/sw

c.c. - Dr. N.L. Goodwin  
- Mr. D.J. Penfold

COPY OF HEALTH SERVICES QUESTIONNAIRE  
AND HEALTH PERSONNEL INVENTORY  
DEPARTMENT OF CORRECTIONAL SERVICES  
434 UNIVERSITY AVENUE • TORONTO 100 • ONTARIO



TELEPHONE  
965-4329

April 28, 1972.

(SENT TO THE SUPERINTENDENTS OF ALL INSTITUTIONS AND SCHOOLS)

As you know, the Minister has asked me to enquire into the provisions for the delivery of health care services at all levels throughout the Department. I have already obtained from the Deputy Minister, Director of Medical Services, Administrators and other officers, a great deal of useful information and this is being supplemented by visits to a number of Jails, to Correctional Institutions and to Training Schools. The co-operation that my colleagues and I have received has been most helpful and much appreciated.

It is desirable to have certain data about health resources and services on a reasonably uniform basis for each institution or school to provide a factual background for my assessment of the situation. It will be appreciated, therefore, if you would have the attached Questionnaire pertaining to health services in your institution completed and returned to me by May 15, 1972.

I realize that you are busy people and we have endeavoured to minimize our demands on your time and attention. The Questionnaire generally calls for a simple 'yes' or 'no' response and a minimum of data. Where statistics are requested we are referring to readily available data and do not intend to have you carry out special studies or analyses to produce the information. On the other hand, we will be glad to receive a copy of any other statistics or reports you have which may throw light on any aspect of the health care delivery system.



Should you wish to add any further information, comments or opinion which you think would be helpful, these would be most welcome and would be treated as confidential if you so indicate.

In addition to this Questionnaire I am enclosing copies of a 'Health Personnel Inventory' form, one of which is to be completed by each member of the health services staff - medical officers, nurses, dentists and others engaged solely or primarily for health care duties. These forms should be returned with the Questionnaire for the Jail, Correctional Institution or Training School, but could be sent directly to me by the individual staff member.

With kindest regards, and thank you.

Yours sincerely,



E.H. BOTTERELL, M.D.

EHB/sw  
Enclosures

N.B. - Please return Questionnaire and Personnel Inventory forms by first class mail BY MAY 15, 1972, to:

Dr. E.H. Botterell,  
c/o Department of Correctional Services,  
434 University Avenue, Room 411,  
Toronto 100, Ontario.

Copies sent for information to:

Deputy Minister  
Executive Director, Professional Services  
Director of Medical Services  
Administrators (Jails, Adult Female and Adult Male Institutions  
and Training Schools)  
Chief Inspector  
Executive Director, Administrative and Financial Services

CORRECTIONAL INSTITUTIONS AND TRAINING SCHOOLS  
(INCLUDING CAMPS, CLINICS AND JAILS)

1. Name of Institution or School \_\_\_\_\_
2. Location (address in full) \_\_\_\_\_
3. Type (specify Centre, School, Jail, etc.) \_\_\_\_\_
4. Category (inmates or wards) (check): Adults \_\_\_\_\_ Juveniles \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_
5. Name of Superintendent \_\_\_\_\_
6. Capacity \_\_\_\_\_
7. Number in custody or residence as at March 31, 1972 \_\_\_\_\_
8. Committed, admitted or re-admitted during year ended March 31/72 \_\_\_\_\_
9. Average daily census (population count) during the year ended March 31, 1972 \_\_\_\_\_
10. Does this institution or school have a hospital or infirmary, i.e., a separate room or rooms with beds set up for in-patient care?  
Yes \_\_\_\_\_ No \_\_\_\_\_
11. Does this institution or school have any full-time health staff, i.e., medical, dental, nursing or other staff (excluding correctional officers) employed solely or primarily for health care duties? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Does this institution or school provide or operate any health services (preventive, diagnostic, treatment, or rehabilitative) on a clinic or ambulatory basis; i.e., other than, or in addition to, in-patient care and sick parades?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, specify \_\_\_\_\_

II. IN-PATIENT (BED) CARE

1. How many beds are set up for patient care? \_\_\_\_\_
2. What would be the rated bed capacity? (Single patient's room 100 sq.ft. per bed; multiple bed room 80 sq.ft.\*; child's single room 80 sq.ft.\*\*; children's ward 50 sq.ft.) \_\_\_\_\_
3. How many of the beds set up are of a type specifically designed for hospital use; i.e., are hospital beds? \_\_\_\_\_
4. How many beds are in single rooms? \_\_\_\_\_
5. What other rooms or wards have you and what are their bed sizes?  
 No. of rooms: 2-bed rooms \_\_\_\_\_ 4-bed rooms \_\_\_\_\_  
 Other: (Specify sizes and number of rooms of each size) \_\_\_\_\_
6. Are any rooms or wards designated for specific diagnostic or treatment categories? Give bed capacities:  
 Medical \_\_\_\_\_ Surgical \_\_\_\_\_ Intensive Care \_\_\_\_\_  
 Alcoholics \_\_\_\_\_ Drug Addicts \_\_\_\_\_ Sexual Deviates \_\_\_\_\_  
 Psychiatric \_\_\_\_\_ Convalescent, re-hab or long-term \_\_\_\_\_  
 Isolation (communicable diseases) \_\_\_\_\_ (Obs. (maternity) \_\_\_\_\_
7. How many patient-days (bed-days) of care were given during the year ended March 31, 1972? \_\_\_\_\_
8. How many patients were admitted (assigned beds) during the year ended March 31, 1972? \_\_\_\_\_
9. How many patients were there (i.e., beds occupied) on 31st March, 1972? \_\_\_\_\_
10. How many deaths were there in this institution or school during the year ended March 31, 1972? \_\_\_\_\_
11. How many deaths of inmates and wards occurred during the year ended March 31, 1972, following transfer to a general, or special hospital? \_\_\_\_\_
12. How many deaths (No. 10 & No. 11) were attributed to:  
 Accidental injury \_\_\_\_\_ Accidental poisoning \_\_\_\_\_ Suicide \_\_\_\_\_ Diseases \_\_\_\_\_
13. Does the institution or school have one or more operating rooms?  
 Yes \_\_\_\_\_ If yes, give number \_\_\_\_\_ No \_\_\_\_\_
14. If yes, give number of visits of patients in the operating room(s) during the year ended March 31, 1972, for:  
 Operations \_\_\_\_\_ Treatments \_\_\_\_\_ Examinations \_\_\_\_\_ Deliveries (Abs) \_\_\_\_\_

\*Minimum width 11.5 ft.

\*\* Minimum width 8 ft.

### III. LABORATORY AND OTHER DIAGNOSTIC SERVICES

Indicate the nature and extent of laboratory and other diagnostic services provided or obtained on behalf of patients of this institution or school during the year ended March 31, 1972. In the last column identify the other institutions or facilities from which services were obtained during the year.

Type of Service	Services provided in this institution or school		Services provided elsewhere (identify institution or facility providing the service)
	Give numbers as appropriate	Give numbers of patients involved	
<u>Blood:</u> Samples taken			
Syphilis tests - Total			
- Wasserman			
- VDRL			
Sugar estimates			
Haemoglobin estimates			
Sedimentary rate estimates			
Cell counts done - RBC			
- WBC			
<u>Urine:</u> Samples taken			
Sugar estimates			
Albumin estimates			
<u>X-Ray Exams:</u> Miniature films for TB			
Large films for TB			
Other X-Ray film exams			
Fluoroscopic exams			
<u>Vision Tests:</u> Total			
Tonometry			
Snellen chart			
Other			
<u>Hearing Tests:</u> Total			
Audiometer			
<u>Electrocardiograms</u>			
<u>Electroencephalograms</u>			
<u>Cytology:</u> Cervical "Pap" smears			
Test results obtained			
<u>Bacteriology &amp; Virology:</u>			
Gonorrhea tests - Smears taken			
- Culture done			
Other tests - Numbers			
- Results obtained			
<u>Measurements and Screening Tests:</u>			
Height & Weight taken			
Skinfold			
Other			

IV. HEALTH PERSONNELPersons engaged solely or primarily for health care duties

If inmates/students are employed in health duties, indicate on the reverse only the types of duties and average daily numbers employed for each type, exclude occasional.

Category	Persons employed as at Mar. 31, 1972						Approved positions at March 31, 1972	Appointments during year ended Mar. 31/72	Separations during year ended Mar. 31/72
	Full-time (incl. shared F.T.)	Part-time	Sessional	Fees	Other	Total			
<u>Medical Staff (MDs)</u>									
Physicians									
Psychiatrists									
Radiologists									
Other MD's									
Total									
<u>Nursing Staff</u>									
Registered nurses									
Other graduate nurses									
Registered nursing assistants									
Other nursing staff									
Total									
<u>Dental Staff</u>									
Dentists									
Dental Hygienists									
Dental assistants									
Dental technicians									
Total									
<u>Other Categories</u>									
Pharmacists									
Radiological technicians									
Laboratory technologists									
Other: *(specify)									
Total									
GRAND TOTAL									

\* Include correctional officers, clerks, typists, psychologists, psychometrists, dieticians, physiotherapists, social workers, etc., only if engaged solely or primarily for health care.



V. HEALTH CARE RECORDS (DOCUMENTATION)

- A. The major health care form seems to be the Medical Status Summary, Form 9801 (formerly Form 14) and the supplementary Treatment Record (continued) Form 9802.

Please provide the information requested below about the use of this form in your institution or school:

1. Is the Form 9801 used in your institution or school? Yes \_\_\_\_\_ No \_\_\_\_\_
2. If yes, when is it initiated? (check) On admission \_\_\_\_\_  
Occurrence of illness or injury \_\_\_\_\_ Within 48 hrs. of admission \_\_\_\_\_  
For medical exam only \_\_\_\_\_ On hospitalization only \_\_\_\_\_  
On discharge: From hospital \_\_\_\_\_ From institution or school \_\_\_\_\_
3. Who makes entries on it? (check one or more)  
M.O. \_\_\_\_\_ Psychiatrist \_\_\_\_\_ Head Nurse \_\_\_\_\_  
Other Nurse \_\_\_\_\_ Superintendent \_\_\_\_\_ C.O.\* \_\_\_\_\_  
Other: (specify) \_\_\_\_\_
4. Where is the form filed while the person is in the institution or school?  
M.O.'s office \_\_\_\_\_ Records room of institution or school \_\_\_\_\_  
Hospital \_\_\_\_\_ Inmate Records, Toronto \_\_\_\_\_ Elsewhere (specify) \_\_\_\_\_
5. Do inmates or wards handle or file Form 9801 (9802) Yes \_\_\_\_\_ No. \_\_\_\_\_
6. How are these records filed?  
Alphabetically \_\_\_\_\_ Chronologically \_\_\_\_\_ Serially (patient or file No.) \_\_\_\_\_
7. How are these records disposed of when person leaves institution or school on discharge (i.e., other than by transfer)?  
Retained in institution or school \_\_\_\_\_ Copy retained \_\_\_\_\_  
Original sent to Inmate Records  
at Main Office in Toronto \_\_\_\_\_ Original destroyed \_\_\_\_\_
8. Are records sent with person transferred to another institution or school? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, is a copy retained at this institution or school? Yes \_\_\_\_\_ No \_\_\_\_\_

\* Correctional Officer

B. Accident or Injury Reports, Form 9890

1. Are all of these reports seen by an M.O.? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is the physician's report section completed only after examination of the person injured? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does the Medical Status Summary Form 9801 also include this information? Yes \_\_\_\_\_ NO \_\_\_\_\_
4. On how many accident and injury reports did the M.O. make a report during the month of March, 1972? \_\_\_\_\_

C. Transferred to Hospital, Form 9811

1. Does the M.O. or a nurse initiate Form 9811 for transfer of a person to hospital for treatment? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, who initiates this Form (9811)? \_\_\_\_\_
2. Does the M.O. or a nurse provide information on which Form 9811 is based? Yes \_\_\_\_\_ No \_\_\_\_\_
3. If yes, is this information recorded on Form 9801 (9802)? Yes \_\_\_\_\_ No \_\_\_\_\_  
and/or some other form? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify form number and attach copy
4. How many transfers to outside hospitals were made on the M.O.'s recommendation during March, 1972? \_\_\_\_\_
5. Do you have statistics of transfers for hospitalization? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please attach statistics of transfers for January to March, 1972 (or some recent three-month period) showing, if possible, numbers of transfers:

(check if available)

- (a) By diagnostic category \_\_\_\_\_
- and/or (b) By nature of treatment recommended \_\_\_\_\_
- and/or (c) By type of operation \_\_\_\_\_

D. Other health reports and records

(Give requested number of forms used only if the information is conveniently available.)

## 1. Do you use:

(a) Form 597, Medical Journal of Jail Surgeons?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give number of entries during the  
year ended March 31, 1972.

(b) Form 686, Physician's Register (Training School)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give number of entries during the  
year ended March 31, 1972.

(c) Other Forms of medical diary?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give number of entries during the  
year ended March 31, 1972.

## 2. Do you use any other health records?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please specify and attach copies of  
forms used:

	<u>Yes</u>	<u>No</u>	<u>No. used during year ended March 31, 1972</u>
Operation reports	_____	_____	_____
Case sheets	_____	_____	_____
Nurses' notes	_____	_____	_____
Dental charts	_____	_____	_____
Medical exam form	_____	_____	_____
Screening questionnaire	_____	_____	_____
Drug report	_____	_____	_____
Other: (specify) _____			_____
_____			_____
_____			_____

## 3. Have you compiled any health statistics on a regular or special basis that would provide information about services given - examinations, treatments - preferably by diagnostic categories encountered in terms of individual patients or visits?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please attach copies of regular reports for a  
recent month or copies of any special reports or studies.

VI. PHYSICAL FACILITIES

1. Does the senior M.O. have an office for administration, interviews, study, etc., physically separate from other rooms?  
and of adequate size? Yes \_\_\_\_\_ No \_\_\_\_\_  
Yes \_\_\_\_\_ No \_\_\_\_\_  
\*Size \_\_\_\_\_
2. Does the senior M.O. have an examining room in addition to office? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does each other medical officer have one room to himself for office, interview, examination and/or treatment purposes? Yes \_\_\_\_\_ No \_\_\_\_\_  
\*Size \_\_\_\_\_
4. Does each medical officer have available an additional examining room for sick parades? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Does the head (or senior) nurse have a room to himself (herself) for office, interviews, examination and/or other health purposes? Yes \_\_\_\_\_ No \_\_\_\_\_  
\*Size \_\_\_\_\_
6. Are additional examining rooms available for other nurses' use for office, examination and/or other health purposes? Yes \_\_\_\_\_ No \_\_\_\_\_
7. How many rooms does the dentist have to himself for office, examination and/or treatment purposes?  
No room \_\_\_\_\_ One room \_\_\_\_\_ Two rooms \_\_\_\_\_ \*Size of largest room \_\_\_\_\_
8. Is there a room for examination or treatment provided for dental hygienists? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Is there an examining table: In M.O.'s office? Yes \_\_\_\_\_ No \_\_\_\_\_  
Elsewhere? (specify) \_\_\_\_\_
10. Is there a dental chair: In dentist's office? Yes \_\_\_\_\_ No \_\_\_\_\_  
Elsewhere? (specify) \_\_\_\_\_
11. Is there a separate room for use as a drug dispensary? Yes \_\_\_\_\_ No \_\_\_\_\_  
\*Size \_\_\_\_\_  
If not, where are drugs kept? \_\_\_\_\_
12. Are medical documents (charts, Form 9801, etc.) filed in doctor's office? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, where are they filed? \_\_\_\_\_
13. Does the institution or school have any emergency facilities or equipment? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, specify \_\_\_\_\_  
\_\_\_\_\_

\* Give dimensions, length by width, in feet, or area in square feet, and indicate which used.

VII. SICK PARADE

1. Is a regular sick parade (excluding "pill parade") held Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give frequency:  
Once a day \_\_\_\_\_ More frequently (specify) \_\_\_\_\_  
Twice a day \_\_\_\_\_ Less frequently (specify) \_\_\_\_\_  
Three times a day \_\_\_\_\_ Request only \_\_\_\_\_
2. Is a sick parade (pill parade) also held for distribution of medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give frequency \_\_\_\_\_ and average daily attendance \_\_\_\_\_
3. Where is the regular sick parade\* held?  
In M.O.'s office? \_\_\_\_\_ In hospital or infirmary? \_\_\_\_\_  
Elsewhere? (specify) \_\_\_\_\_
4. Is there a waiting room for persons waiting to see M.O. for sick parade or otherwise? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Are interviews and/or examinations conducted privately, i.e., in a separate room or cubicle, separated by walled partitions and curtains? Interviews privately Yes \_\_\_\_\_ No \_\_\_\_\_  
Examinations privately Yes \_\_\_\_\_ No \_\_\_\_\_
6. Are all inmates or students able to see an M.O. on sick parade\* or otherwise on request? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Are requests to see the M.O. screened? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, by nurse? \_\_\_\_\_ Or by C.O.? \_\_\_\_\_
8. Is the M.O. advised of those screened and not seen by him? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, in what detail? Name only \_\_\_\_\_  
Health problem or complaint \_\_\_\_\_
9. How many requests to see the M.O. (prior to any screening) were made during the year ending March 31, 1972? \_\_\_\_\_
10. How many of these requests (No. 9) during the year resulted in the person: (a) Seeing the M.O. \_\_\_\_\_  
(b) Seeing the nurse only \_\_\_\_\_
11. What was the attendance at sick parades\* during the year ended Mar. 31/72? Total number \_\_\_\_\_ Average daily number \_\_\_\_\_  
Number for March, 1972 \_\_\_\_\_ Average number per parade \_\_\_\_\_
12. Are entries made on Form 9801 (9802) for all sick parade attendances? Yes \_\_\_\_\_ No \_\_\_\_\_

\* Excluding "pill parade."

Apr. 25/72



HEALTH PERSONNEL INVENTORY

(all persons employed or engaged by the Department of  
Correctional Services solely or primarily for health duties)

1. Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_\_

3. Employment with the Department of Correctional Services:

Present position (title and/or class) \_\_\_\_\_

Employed in present position since? \_\_\_\_\_

Employed in Department since? \_\_\_\_\_

Employment type: \_\_\_\_\_

Full-time \_\_\_\_\_ Shared full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Sessional \_\_\_\_\_ Fees \_\_\_\_\_ Other (specify) \_\_\_\_\_

If not engaged full-time, please indicate time committed:

(a) Hours per day \_\_\_\_\_ and days per week \_\_\_\_\_

or (b) Number of half-day sessions per week \_\_\_\_\_

For full-time or other employment indicate:

Overtime - (other than on-call) for which financial or time  
compensation would be given in the last week:

Hrs. per week \_\_\_\_\_

On-Call - indicate pattern of "on-call" service for yourself;  
e.g., frequency per week or month \_\_\_\_\_

4. Previous experience, excluding Department  
(show particularly, significant positions and periods):

List chronologically, in reverse order (i.e., most recent first) -

<u>Type of position or practice</u>	<u>Employer</u> (where applicable)	<u>Period</u> (years or dates)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Education:

<u>Course</u>	<u>University or School</u>	<u>Degree or Diploma</u>	<u>Period</u> (years or dates)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Apr. 28/72.

(If necessary, use other side.)

MEDICAL RECORD STUDIES

APPENDIX 9

a) COMPOSITION OF RESEARCH TEAMS

and

LIST OF JAILS, CORRECTIONAL CENTRES AND TRAINING SCHOOLS

SELECTED FOR MEDICAL RECORD STUDIES

University of Toronto Team

Directed by - Dr. Harding le Riche,  
Professor and Head,  
Department of Epidemiology and Biometrics,  
School of Hygiene,  
University of Toronto.

Research Assistants - Mr. Andrew Pakula, B.Sc.  
- Miss Grazyna Kwiatkowska

<u>Priority</u>	<u>Institution or School</u>	<u>Dates of visits</u> (1972)
1	Grandview Training School and Reception and Diagnostic Centre (girls)	June 21
2	Vanier Centre for Women	June 27
3	Toronto (Don) Jail	started May 24
4	Mimico Correctional Centre	July 4
5	Brampton Adult Training Centre	June 29
	Brampton Jail	June 29
6	Hillcrest Training School (boys)	July 6

Queen's University Team

Directed by - Dr. Robert Steele,  
Professor and Head,  
Department of Community Health and Epidemiology,  
Queen's University.

and - Dr. Arthur Kraus,  
Professor of that Department.

Research Assistants - Miss Gwen Thompson  
- Mrs. Ida McDonald

<u>Priority</u>	<u>Institution or School</u>	<u>Dates of visits</u> (1972)
1	Pine Ridge Training School (boys)	June 7
2	Guelph Correctional Centre and Neuro-Psychiatric Clinic	June 8, 28, 29
3	Quinte Regional Detention Centre	May 25
4	Ottawa Jail	May 31
5	Millbrook Correctional Centre	May 18

- b) Explanatory Notes: Extracts from memoranda and letter from  
Dr. Josie to Drs. le Riche, Steele and Kraus

Letter dated April 21, 1972:

"This is further to our discussion on Thursday, April 13th and subsequent telephone conversation about the medical record studies. You will recall that we spent some time at the meeting in considering the question of classification or category breakdowns with respect to the basic questions -

- (a) what was the complaint or health problem?
- and
- (b) what was done by the health staff?

I think we were in agreement that a simple form of classification would be desirable and expedient in view of the nature of the information likely to be available and the practical difficulties in obtaining any data.

While we appreciate the data limitations at many of the institutions, particularly the jails, as illustrated by your information from the Kingston Jail sick parade, both Dr. Botterell and I think that we should be able to obtain some data in terms of diseases or symptoms. I have drafted the attached list of "Selected Diseases, Symptoms and Ill-Defined Conditions" for your consideration.\* This is based on the ICDA (eighth revision of the ICD adapted for use in the United States; P.H.S. publication 1693, Vol. 1 and 2) and includes a number of diseases selected on the basis of anticipated frequency or relative importance, along with symptoms I think you are likely to encounter in records you will be examining. The selection has been made in the light of frequencies encountered and lists used in various morbidity studies, hospital statistics and general practitioners' experience. I have suggested a coding system which involves using a zero in the third digit for diseases in the class or group but not specifically identified and a '9' in the third digit for symptoms or unspecified conditions in the group. It seems to me that such a combination of disease classes, selected diseases and selected symptoms and ill-defined conditions should be sufficiently comprehensive and practical for the purpose of these medical record studies.

Attached also is a suggested classification and code system\*for "Type of Service". This is also based on the ICDA but has been supplemented by a few service items that seemed necessary for completeness in the light of information from other sources."

\*The classification and code systems in Appendix 9(c) and (d) incorporate some of the results of the medical record studies.

Memorandum dated May 5, 1972:

"These studies are independent projects of the Toronto group and Queen's group respectively and any research assistants will be under the direction of Dr. le Riche for the Toronto group and Dr. Steele and/or Dr. Kraus for the Queen's group. It is hoped that a substantial degree of uniformity will be achieved, but the practical circumstances with respect to working conditions and data limitations may dictate certain differences in procedures. In any case, it was agreed that the purpose of the studies is to obtain quantitative answers to the questions (a) what was the complaint or health problem and (b) what was done by the health staff. The first question is to be answered in terms of the "Selected Diseases, Symptoms and Ill-Defined Conditions" code and the second in terms of the "Type of Service" code. Dr. Botterrell indicated that he wanted information which would help to determine the extent to which patients could be seen by a nurse rather than a medical doctor. The source documents for both answers are generally to be the Medical Status Summary Form 9801 and its supplement, the Treatment Record (continued) Form 9802. These are to be sampled or selected on as scientific and objective a basis as feasible. It was suggested that the records for persons discharged from a jail or institution for a one-month to three-month period, say January to March 1972, might suffice. In any case recent records are to be used and in sufficient volume to provide an indication of relative frequencies of "Diseases" etc., categories and "Services" types. The unit of study is the entry on the record corresponding to a visit, medical attendance, sick parade or other encounter of the patient with the physician or other member of the health services staff. While it would be desirable to distinguish new visits (incidence) from repeat visits or all visits (prevalence), this is probably not practicable but some data might be obtained on a supplementary sample basis."

Memorandum dated May 19, 1972:

"In earlier correspondence I referred to the unit of study as the entry on the record corresponding to a visit, medical attendance, sick parade, or other encounter of the patient with the physician, etc. It seems to me that we might well adopt Dr. Kraus' term; i.e. contact. We are therefore interested in counts of contacts and of individuals. We also wish to distinguish health problems encountered at the admission examinations from those recorded on other contacts. I thought it might be helpful to send you the attached sheet\* showing dummy tables of the kind I anticipate will result from your work.

The "sample" is essentially a set of medical records, forms 9801, for individuals discharged from an institution during the month of March, 1972, and preceding months as required to build up our study volume. Generally, we will be concerned with all contacts, problems and services recorded on the Form 9801/2 for the individual at any time. Should the volume become excessive, we could confine our attention to contacts at the institution in which the record is being examined but it is preferable to have the full experience."



MEDICAL RECORD STUDIES

APPENDIX 9  
(PAGE 5)

c) SELECTED DISEASES, SYMPTOMS AND ILL-DEFINED CONDITIONS

CLASSIFICATION AND CODE NUMBERS

<u>Code No.</u>		<u>ICDA *</u> <u>Nos.</u>
	<u>I. Infective and parasitic diseases</u>	
010	Diseases in Class I NES**	
011	Tuberculosis, all forms	010-019
012	Infectious hepatitis	070
013	Infectious mononucleosis	075
014	Pediculosis	132
015	Syphilis	090-097
016	Gonococcal infections	098
017	Warts	079.1
019	Symptoms, etc., in Class I NES	
	<u>II. Neoplasms - Code 020-029</u>	
	<u>III. Endocrine, nutritional and metabolic diseases</u>	
030	Diseases in Class III NES	
031	Hyper and hypo thyroidism	242-244
032	Diabetes mellitus	250
033	Protein and other nutritional deficiency	267-269
034	Obesity	277
039	Symptoms, etc., in Class III NES	
	<u>IV. Diseases of blood and blood-forming organs</u>	
040	Diseases in Class IV NES	
041	Anemias	280-285
049	Symptoms, etc., in Class IV NES	
	<u>V. Mental disorders</u>	
050	Psychoses	290-299
051	Anxiety and other neuroses NES	300
052	Hysteria (neurosis)	300.1
053	Depression (neurosis)	300.4
054	Psychopath and other personality disorders	301
055	Sexual deviation	302
056	Alcoholism	303
057	Drug dependence	304
058	Mental retardation	310-315
059	Symptoms, etc., in Class V NES	

<u>Code No.</u>		<u>ICDA Nos.</u>
<u>VI. Diseases of nervous system and sense organs</u>		
060	Diseases in Class VI NES	
061	Epilepsy	345
062	Inflammatory diseases of the eye	360-369
063	Refractive errors (including vision loss)	370
064	Vertigo: dizziness, giddiness	780.5
065	Disturbance of sleep	780.6
069	Symptoms, etc., in Class VI NES	incl. 780, 781 NES
<u>VII. Diseases of the circulatory system</u>		
070	Diseases in Class VII NES	
071	Hypertensive disease	400-404
072	Arteriosclerosis	440
073	Varicose veins of lower extremities	454
074	Hemorrhoids	455
075	Palpitation and tachycardia	782.1, 782.2
076	Syncope or collapse: fainting	782.5
077	Enlargement of lymph node	782.7
079	Symptoms, etc., in Class VII NES	incl. 782 NES
<u>VIII. Diseases of the respiratory system</u>		
080	Diseases in Class VIII NES	
081	Acute nasopharyngitis (common cold)	460
082	Bronchitis and emphysema	490-492
083	Asthma	493
084	Dyspnea: shortness of breath	783.2
085	Cough	783.3
089	Symptoms, etc., in Class VIII NES	incl. 783 NES
<u>IX. Diseases of digestive system</u>		
090	Diseases in Class IX NES	
091	Ulcer of stomach and duodenum	531-533
092	Appendicitis	540-543
093	Hernia of abdominal cavity	550-553
094	Nausea and vomiting	784.1
095	Abdominal swelling and pain	785.0, 785.5
096	Diseases of teeth and gums	520-525
099	Symptoms, etc., in Class IX NES	incl. 784, 785 NES

Code  
No.

ICDA  
Nos.

X. Diseases of genitourinary system

100	Diseases in Class X NES	
101	Vaginal discharge	629.3
109	Symptoms, etc., in Class X NES	incl. 786 NES

XI. Complications of pregnancy, childbirth and puerperium

110	Diseases in Class XI NES	
111	Delivery without mention of complication	650
112	Normal pregnancy without delivery	Y06
119	Symptoms, etc., in Class XI NES	

XII. Diseases of skin and subcutaneous tissue

120	Diseases in Class XII NES	
121	Rash: skin eruption NES	788.2
122	Cysts	706.2
124	Skin infection	686
125	Allergies other than allergy to penicillin	692
129	Symptoms, etc., in Class XII NES	

XIII. Diseases of musculoskeletal system and connective tissue

130	Diseases in Class XIII NES	
131	Arthritis, rheumatism, excl. rheumatic fever	710-718
132	Pain and swelling in leg, arm, etc.	787.1, 787.2
133	Pain and swelling of joint: arthralgia	787.3, 787.4
139	Symptoms, etc., in Class XIII NES	incl. 787 NES

XIV. Congenital anomalies - Code 140-149

XV. Certain causes of perinatal morbidity and mortality - Code 150-159

XVI. Symptoms, ill-defined conditions, etc.

160	Observation - no health problem detected	793
161	Follow-up examination; positive check-up; including fit for travel	
162	Pill (medication) given - no exam or other care	
163	Loss of weight	788.4
164	Nervousness & debility NES, incl. "cell door open"	790
165	Headache, pain in head, NES	791
166	Seizure, convulsion, fit, NES	780.2
167	Chest pain NES	783.7
168	Senility without mention of psychosis	794
169	Symptoms and ill-defined conditions NES	

<u>Code No.</u>		<u>ICDA Nos.</u>
	XVII. <u>Accidents, poisonings and violence</u> ***	
170	Fracture of skull, spine and trunk	800-809
171	Fracture of limb (upper and lower)	810-829
172	Dislocation, sprains and strains	830-848
173	Intracranial injury (excl. skull fracture)	850-854
174	Internal injury of chest	860-862
175	Internal injury of abdomen	863-868
176	Laceration and open wound	870-907
177	Contusion and crushing with intact skin surface, incl. bruise	920-929
178	Burn	940-949
179	Accidents, etc., in Class XVII NES including allergy to penicillin	

\* ICDA Nos. - Eighth Revision International Classification  
of Diseases adapted for use in the United States.  
U.S. PHS publication No. 1693 Vol. 1(1967); Vol. 2(1969).

\*\* NES - Not Elsewhere Specified.

\*\*\* Use 'X' as 4th digit to indicate self-inflicted injury.

- NOTES:
1. 0 in 3rd digit is generally used for NES diseases - medically diagnosed.
  2. 9 in 3rd digit is generally used for NES symptoms - patient's statement.
  3. Write in and assign number to any unspecified disease or symptom occurring frequently.

d) TYPE OF SERVICE

CLASSIFICATION AND CODE NUMBERS

	<u>Code</u>
<u>Examinations and tests</u>	
Routine physical examination on admission	01
Follow-up examination or recheck	02
Complete or general physical examination	03
Partial or incomplete physical examination	04
Physical measurements taken - height, weight, T.P.R.	05
Psychiatric examination (incl. "saw psychiatrist")	06
Neurological examination, complete	07
Skin immunity and sensitization tests (incl. TB tests)	08
Other examinations and tests (incl. contacts and carriers)	09
<u>Visits, medications and diets</u>	
Consultation and advice: counselling and teaching	31
Assessment of fitness for duty or transfer	32
Rest recommendation	34
Referred to - psychiatrist	41
- other medical specialist	42
- nurse	43
- dentist	44
- psychologist, psychometrist	45
- physical or occupational therapist	46
- teacher	47
- outside hospital	48
- optometrist	49
Medication (pills and other) - administered	51
- prescribed	52
- distributed	53
Diet - special diet prescribed	61
- special diet discontinued	62
<u>Operations and non-surgical procedures</u>	
Operation or surgical procedure*	11
Biopsy	12
Diagnostic endoscopy	13
Diagnostic radiography	14
Physical medicine and rehabilitation (incl. soaks & compresses)	15
Prophylactic inoculation & vaccination (incl. tetanus & polio)	16
Dressing of wounds	17
Application of equipment (i.e. tensor, splint, cast)	18
Specimen or sample taken for diagnostic test	
- urine	21
- blood	22
- sputum, nose or throat swab	23
- urethral, vaginal, cervical smear (specimen)	24
Analysis or test performed	25
Analysis or test result interpreted**	26
Equipment dispensed***	27



Code

Hospitalization

In institution or school hospital, sick bay or infirmary	
- admitted to hospital (institution or outside)	71
- visited in hospital	72
- discharged from hospital	73

\* 11. Including removal of wart, boil, tattoo, cyst, blister, splinter; appendectomy; tonsillectomy; plastic surgery.

\*\* 26. Including blood, liver function, glucose tolerance tests; VDRL; cervix, pregnancy tests; urinalysis; throat swab; cultures and smears; EEG; ECG.

\*\*\* 27. Including glasses; appliances and prostheses prepared and repaired; fracture board dispensed.

MEDICAL RECORD STUDIES  
e) DRAFT (DUMMY) TABLES  
(GHJ/sw, 19/5/72)

APPENDIX  
(PAGE 11)

TABLE 1 - INDIVIDUALS AND CONTACTS BY DISEASE CATEGORY

Contact or meeting of inmate recorded on 9801/2, by  
Contact= M.O., nurse, or other person giving health care or attention

Disease Category	A. Admission Exam.	B. Other Contacts	
	No. Individuals	No. Contacts	No. Individuals
010			
.			
.			
.			
.			
.			
179			
TOTAL			
Total Individuals (unduplicated count) = number of Forms 9801			

TABLE 2 - INDIVIDUALS AND CONTACTS BY TYPE OF SERVICE

Type of Service	No. Contacts	No. Individuals
01		
.		
.		
.		
.		
.		
73		
TOTAL		

TABLE 3 - INDIVIDUALS BY NUMBER OF CONTACTS

(1) Number of Contacts	(2) No. Individuals	(3) <u>Individuals</u> Cum. % ex. Admission exam.	(4) <u>Contacts</u> (1) x (2) = (4)
Admission exam.			
Other contacts - 0			
- 1			
- 2			
- 3			
.			
.			
.			
.		100.0%	
TOTAL		//////////	

TABLE 1\*

APPENDIX 9.

(PAGE 12)

DISEASES AND SYMPTOMS RECORDED IN JAILS - BY JAIL (RDC)

Cases recorded on Forms 9801-2 at admission examinations (A) and other contacts (O)

(Records may not include entries for screening or treatment by nurses or C.O.'s)

Code No.	Disease, Injury or Symptom	Toronto		Brampton		Quinte RDC		Ottawa	
		A	O	A	O	A	O	A	O
010	Diseases in Class I NES	1	1				1		
011	Tuberculosis, all forms	2							
014	Pediculosis								1
016	Gonococcal infections					1			
019	Symptoms, etc., in Class I NES	2							
030	Diseases in Class III NES		1						
031	Hyper and Hypo thyroidism	2	1						
032	Diabetes mellitus	3						1	1
033	Protein & other nutritional deficiency	7		1					
034	Obesity	8							
041	Anemias					1			
050	Psychoses	6						1	1
051	Anxiety & other neuroses NES	1	2					1	1
053	Depression (neurosis)	1	1			2		1	1
054	Psychopath & other personality disorders		6					1	2
056	Alcoholism	58						4	1
057	Drug dependence	36		1		2	1	2	
058	Mental retardation	2							
059	Symptoms, etc., in Class V NES		1						
060	Diseases in Class VI NES	3	4			1			
061	Epilepsy	11	1			1	1	2	1
062	Inflammatory diseases of the eye	1				1			
063	Refractive errors (incl. vision loss)	4							
064	Vertigo: dizziness, giddiness	3	2			2	1		
065	Disturbance of sleep	1	4		1	9	10	1	8
069	Symptoms, etc., in Class VI NES	3							
070	Diseases in Class VII NES	1				2			
071	Hypertensive disease	3						2	2
074	Hemorrhoids	1					2		2
075	Palpitation and Tachycardia							1	
076	Syncope or collapse: fainting		2						
077	Enlargement of lymph node		1						
079	Symptoms, etc., in Class VII NES					2	1	1	2

TABLE 1 (Cont'd.)

APPENDIX 9

(PAGE 13)

Code No.	Disease, Injury or Symptom	Toronto		Brampton		Quinte RDC		Ottawa	
		A	O	A	O	A	O	A	O
080	Diseases in Class VIII NES	1							
081	Acute Nasopharyngitis (cold)	15	9		2	5	9	3	7
082	Bronchitis & emphysema	16					1		1
083	Asthma	5		1	1				
084	Dyspnea; shortness of breath		1		1				
085	Cough	2	3		2	2			1
089	Symptoms, etc., in Class VIII NES	2	1			2	1		
090	Diseases in Class IX NES	2	3					1	
091	Ulcer of stomach & duodenum	10							
093	Hernia of abdominal cavity	1							
094	Nausea and vomiting	3	3						
095	Abdominal swelling and pain	2	4	1	1	1			
096	Diseases of teeth and gums	3	9		1				
099	Symptoms, etc., in Class IX NES	3	3			6	9	3	8
100	Diseases in Class X NES	3	1						
109	Symptoms, etc., in Class X NES	2				1			1
112	Normal pregnancy without delivery	6							
120	Diseases in Class XII NES	7	1				1		
121	Rash; skin eruption NES	5	3			2	3	2	3
129	Symptoms, etc., in Class XII NES	8	4				1		1
130	Diseases in Class XIII NES	3				1		1	
131	Arthritis, rheumatism, excluding rheumatic fever	3						1	
133	Pain & swelling of joint: arthralgia					1			
139	Symptoms, etc., in Class XIII NES						1	1	1
140	Diseases in Class XIV NES	1				2	1		
163	Loss of weight					1			
164	Nervousness & debility NES, including "cell door open"	1	1			16	4	6	6
165	Headache, pain in head, NES	2	5	1	1	1		2	2
166	Seizure, convulsion, fit, NES		2						
167	Chest pain NES	4	3						
169	Symptoms and ill-defined conditions NES	5	6	1					

TABLE 1 (Cont'd.)

APPENDIX 9  
(PAGE 14) \*

Code No.	Disease, Injury or Symptom	Toronto		Brampton		Quinte RDC		Ottawa	
		A	O	A	O	A	O	A	O
170	Fracture of skull, spine & trunk	1				1		1	
171	Fracture of limb (upper & lower)	3				5	1	1	
172	Dislocation, sprains & strains	2				1	1	1	
176	Laceration and open wound	11	1	2	1		1	1	1
177	Contusion and crushing with intact skin surface, incl. bruise	14			1	1			
178	Burn	2	1						
179	Accidents, etc., in Class XVII NES incl. allergy to penicillin	4							
Totals - Admission exams - 435		312		8		73		42	
Totals - Other contacts - 209			91		12		51		55
GRAND TOTAL 644		403		20		124		97	
Number of Inmates 700		400		100		100		100	

\* See footnotes to Table 5 (Page 41) and List, Appendix 9(c) (Pages 266-269)



TABLE 2 \*

DISEASES AND SYMPTOMS RECORDED IN CORRECTIONAL CENTRES (AND ATC)  
BY CENTRE

Cases recorded on Forms 9801-2 at admission examinations (A) or other contacts (O)  
(Records may not include entries for screening or treatment by nurses or C.O.'s)

Code No.	Disease, Injury or Symptom	Vanier		Brampton		Mimico		Millbrook		Guelph	
		A	O	A	O	A	O	A	O	A	O
011	Tuberculosis, all forms					1					
014	Pediculosis									3	4
015	Syphilis	1	2			1		1		1	
016	Gonococcal infections	4				1					1
017	Warts			3		3					
019	Symptoms, etc., in Class I NES										1
020	Diseases in Class II NES							1			
031	Hyper & hypo thyroidism	1	1							1	
032	Diabetes mellitus					11					
033	Protein and other nutritional deficiency	1				6					
034	Obesity	5				2				5	
039	Symptoms, etc., in Class III NES										1
041	Anemias					3					
050	Psychoses					1	1				
051	Anxiety & other neuroses NES	2	5	1	2	5	3		2	2	6
052	Hysteria (neurosis)	1							1	1	1
053	Depression (neurosis)	3	1			1	4		1	1	
054	Psychopath and other personality disorders		1			1	3			2	4
056	Alcoholism					48		1	1	2	3
057	Drug dependence	14		2		27				17	
059	Symptoms, etc., in Class V NES										1
060	Diseases in Class VI NES		1		1	3					1
061	Epilepsy					9		1		2	
062	Inflammatory diseases of eye	1	2		1	2	3				
063	Refractive errors (incl. vision loss)	3	1	5		1				9	14
064	Vertigo: dizziness, giddiness		3			1	1			1	2
065	Disturbance of sleep	2			3	6	16			2	14
069	Symptoms, etc., in Class VI NES	2	4		3	1	4		15	3	6

TABLE 2 (Cont'd.)

APPENDIX 9  
(PAGE 16)

Code No.	Disease, Injury or Symptom	Vanier		Brampton		Mimico		Millbrook		Guelph	
		A	O	A	O	A	O	A	O	A	O
070	Diseases in Class VII NES		1			1					
071	Hypertensive disease					4	2				
073	Varicose veins of lower extremities					1					
074	Hemorrhoids		1			1					3
075	Palpitation & tachycardia						1				
076	Syncope or collapse; fainting		1								
079	Symptoms, etc., in Class VII NES										2
080	Diseases in Class VIII NES				1			1	2		
081	Acute nasopharyngitis (cold)	4	13	1	13	8	39		13	13	44
082	Bronchitis & emphysema					10	2			3	2
083	Asthma	1		1		4					1
084	Dyspnea: shortness of breath	1				1				1	
085	Cough	1	3		1	2	9			4	20
089	Symptoms, etc., in Class VIII NES								2	2	20
090	Diseases in Class IX NES	2	3	2	1	5	4		2		
091	Ulcer of stomach & duodenum	1				10		1	4		
093	Hernia of abdominal cavity					3				1	1
094	Nausea and vomiting	1	4		1	3					7
095	Abdominal swelling & pain	2	7		3	17	5		2	4	9
096	Diseases of teeth & gums		2		2	11	8				
099	Symptoms, etc., in Class IX NES	2				2		1	21	23	29
100	Diseases in Class X NES	5	13		1	2	2				
101	Vaginal discharge	12									
109	Symptoms, etc., in Class X NES				1		1		2	1	8
112	Normal pregnancy without delivery	3									
120	Diseases in Class XII NES	2	5	3	5	3	6			1	
121	Rash: skin eruption NES		3	1	4	6	7		14	16	27
122	Cysts	1	2	1		1			3		4
124	Skin infection					4	6				
125	Allergies other than allergy to penicillin					5					
129	Symptoms, etc., in Class XII NES			1	1				2	1	1

TABLE 2 (Cont'd.)

APPENDIX 9

(PAGE 17)

Code No.	Disease, Injury or Symptom	Vanier		Brampton		Mimico		Millbrook		Guelph	
		A	O	A	O	A	O	A	O	A	O
130	Diseases in Class XIII NES						1			2	
131	Arthritis, rheumatism, excluding rheumatic fever					2					
132	Pain & swelling in leg, arm, etc.		5		2		2				3
133	Pain & swelling of joint: arthralgia		3			3	1		1	1	3
139	Symptoms, etc., in Class XIII NES	2	3	1	1	6			9	6	21
140	Diseases in Class XIV NES			1		2					
160	Observation - no health problem detected								5		
163	Loss of weight								1		
164	Nervousness & debility NES, incl. "cell door open"	6	8			9	8		3	10	6
165	Headache, pain in head, NES	4	9		4	8	9		5	1	10
166	Seizure, convulsion, fit, NES						2				2
167	Chest pain, NES	1	1	2	5	6	3			2	2
169	Symptoms and ill-defined conditions NES	2	2	1		3	2		1		2
170	Fracture of skull, spine & trunk		1			1	1				
171	Fracture of limb (upper & lower)	1	1	1	2	2	5	2	3		
172	Dislocation, sprains & strains		1		12	2	15		1		11
176	Laceration & open wound		5		11	2	14			1	9
177	Contusion & crushing with intact skin surface incl. bruise	1	3	3	11	4	16	1	10		8
178	Burn		1		2		2		1	1	
179	Accidents, etc., in Class XVII NES					5			1		12
Total - Admission exams		567		95		27		290		9	
Total - Other contacts		885		122		97		211		129	
GRAND TOTAL		1,452		217		124		501		138	
Number of Inmates		640		100		100		267		58	

\* See footnotes to Table 12 (Page 64) and List, Appendix 9(c) (Pages 266-269)

TABLE 3\*

DISEASES AND SYMPTOMS RECORDED IN TRAINING SCHOOLS - BY SCHOOL

Cases recorded on Forms 9801-2 at admission examinations (A) and other contacts (O)  
(Records may not include entries for screening or treatment by nurses or supervisors)

Code No.	Disease, Injury or Symptom	Grandview		Hillcrest		Pine Ridge	
		A	O	A	O	A	O
010	Diseases in Class I NES	1					
013	Infectious mononucleosis					1	1
016	Gonococcal infections			1			
017	Warts	3	7		7		
030	Diseases in Class III NES			1	1		
031	Hyper and hypo thyroidism		1				
033	Protein & other nutritional deficiency			2		2	
034	Obesity	1	2	1		1	
041	Anemias		1				
050	Psychoses			1			
051	Anxiety and other neuroses NES	1		1		7	13
052	Hysteria (neurosis)		1				
053	Depression (neurosis)	1	5	3	7	2	2
054	Psychopath & other personality disorders		2	5	3		1
056	Alcoholism	1					
057	Drug dependence	22		20		13	11
058	Mental retardation			1			
059	Symptoms, etc., in Class V NES				1		1
060	Diseases in Class VI NES	3	2	1	1		
061	Epilepsy			3		2	2
062	Inflammatory diseases of the eye		3	1			
063	Refractive errors (including vision loss)		6	5		5	11
064	Vertigo: dizziness, giddiness	4	6	1	4		4
065	Disturbance of sleep			3	10		2
069	Symptoms, etc., in Class VI NES	1	8		2	4	6
072	Arteriosclerosis						1
076	Syncope or collapse: fainting				1		
079	Symptoms, etc., in Class VII NES					1	1



TABLE 3 (Cont'd.)

APPENDIX 9  
(PAGE 19)

Code No.	Disease, Injury or Symptom	Grandview		Hillcrest		Pine Ridge	
		A	O	A	O	A	O
080	Diseases in Class VIII NES					2	1
081	Acute nasopharyngitis (common cold)	5	49	9	15	3	13
082	Bronchitis and emphysema	1	1				
083	Asthma		1			1	
084	Dyspnea; shortness of breath	1					
085	Cough			1	2		
089	Symptoms, etc., in Class VIII NES				2	9	10
090	Diseases in Class IX NES				1		
091	Ulcer of stomach and duodenum					2	2
092	Appendicitis		1				
094	Nausea and vomiting	1	9		4		1
095	Abdominal swelling and pain	7	16		9		2
096	Diseases of teeth and gums	1	2	1	2		
099	Symptoms, etc., in Class IX NES		1			20	16
100	Diseases in Class X NES	5	3				
101	Vaginal discharge		10				
109	Symptoms, etc., in Class X NES		5	1	1	2	1
112	Normal pregnancy without delivery	2					
120	Diseases in Class XII NES	3	6	5	25	1	1
121	Rash; skin eruption NES	6	5	2	10	3	5
122	Cysts	1	2		3		
124	Skin infection			4			
125	Allergies other than allergy to penicillin	6		2			
129	Symptoms, etc., in Class XII NES					3	1
132	Pain and swelling in leg, arm, etc.	2	1				1
133	Pain and swelling of joint: arthralgia		3				
139	Symptoms, etc., in Class XIII NES		2			1	3
140	Diseases in Class XIV NES			3		2	2



TABLE 3 (Cont'd.)

APPENDIX 9  
(PAGE 20)

Code No.	Disease, Injury or Symptom	Grandview		Hillcrest		Pine Ridge	
		A	O	A	O	A	O
163	Loss of weight		1				
164	Nervousness and debility NES	4	1	4		2	2
165	Headache, pain in head, NES	3	14	3	10		1
166	Seizure, convulsion, fit, NES				2		
167	Chest pain, NES		2		1		
169	Symptoms and ill-defined conditions NES		12	1	8		
170	Fracture of skull, spine and trunk						1
171	Fracture of limb (upper and lower)				4	1	2
172	Dislocation, sprains and strains	1	9		7		5
176	Laceration and open wound	2	14		13	2	7
177	Contusion and crushing with intact skin surface, including bruise	1	18	1	29	2	4
178	Burn	2			1		
179	Accidents, etc., in Class XVII NES including allergy to penicillin	6					1
Totals - admission examinations		275	98	83		94	
Totals - other contacts		560	232		190		138
GRAND TOTAL		835	330	273		232	
Number of Students		237	100	69		68	

\* See footnotes Table 17 (Page 76) and Appendix 9(c) (Pages 266-269)

TABLE 1

## EXPENDITURES ON HEALTH SERVICES - CORRECTIONAL CENTRES AND TORONTO JAIL

Year ending March 31, 1972

## A. SUMMARY

Institution	4. Charges for services (including rentals)			3. Transportation and Communications	5. Supplies and equipment	1 - 7 Grand ** total
	1. Salaries & wages 2. Employee benefits	Personnel* services (fees)	Hospitalization (108)	Total charges		
Vanier	\$ 47,703.76	\$ 38,800.14	\$ 4,580.75	\$ 43,866.35	\$ 6,694.33	\$ 98,277.24
Burton	8,697.37	21,207.45	9,812.60	31,329.87	10,139.67	50,816.11
Burwash	120,828.72	21,793.43	6,429.80	28,386.28	15,717.01	165,127.71
Guelph	136,818.78	24,941.97	16,431.25	42,725.77	22,377.54	202,687.11
Millbrook	17,061.02	9,218.34	4,050.25	13,322.88	10,521.28	41,393.38
Mimico	96,946.15	50,296.90	30,314.62	80,701.51	16,774.96	194,711.22
Monteith	9,980.21	16,023.75	984.20	17,007.95	2,094.22	29,254.99
Rideau	10,163.62	21,086.00	6,541.30	27,627.30	7,230.82	45,165.68
Thunder Bay	686.40	3,481.45	441.60	3,923.05	319.91	4,933.61
Brampton	29,098.89	9,805.50	1,268.89	11,303.40	3,973.45	45,089.29
Total	\$477,984.92	\$216,654.93	\$80,855.26	\$300,194.36	\$95,843.19	\$ 877,456.34
Toronto Jail	181,532.21	43,384.00	4,686.45	48,084.20	16,502.61	246,510.67
TOTAL	\$659,517.13	\$260,038.93	\$85,541.71	\$348,278.56	\$112,345.80	\$1,123,967.01

\*Includes 101, 102, 103, 105 and 106.

\*\*Includes 6 and 7 - both nil.

Source: Data provided by the Office of the Ministry Chief Accountant.

TABLE 1

## EXPENDITURES ON HEALTH SERVICES - CORRECTIONAL CENTRES AND TORONTO JAIL

Year ending March 31, 1972

## B. DETAILS OF EXPENDITURES

INSTITUTION	443xxx Personnel services					560xxx Medical supplies, instruments, etc. (value under \$100)	
	Doctors' fees 101	Psychiatrists' fees 102	Dentists' fees 105	Optometrists' fees 106	Total*	Dental supplies, instruments, etc. 100	Pharmaceutical and medical supplies 300
Vanier	\$ 11,807.20	\$23,725.00	\$ 113.40	\$ 677.54	\$ 43,380.89	\$ 1,248.34	\$ 4,300.32
Burton	17,157.50	1,085.00	133.00	1,282.95	31,020.05	3,015.42	6,092.14
Burwash	13,492.73	35.00	461.93	7,803.77	28,223.23	4,776.53	8,492.13
Guelph	19,572.50	890.00	804.47	3,675.00	41,373.22	3,805.33	10,212.94
Millbrook	6,835.00	605.60	7.74	789.00	13,268.59	4,297.39	2,711.59
Mimico	7,874.30	41,825.10	580.50	17.00	80,611.52	5,797.88	6,313.14
Monteith	6,278.25		8,777.00	968.50	17,007.95		1,292.12
Rideau	9,690.75		7,951.00	3,444.25	27,627.30	96.86	5,982.13
Thunder Bay	1,788.75	35.00	1,574.50	83.20	3,923.05		293.91
Brampton	6,646.50		2,221.00	938.00	11,074.39	988.30	1,654.73
Total Centres	\$101,143.48	\$68,200.70	\$22,624.54	\$19,679.21	\$297,510.19	\$24,026.05	\$47,345.15
Toronto Jail	33,124.00	4,940.00	5,320.00		48,070.45	33.63	14,280.10
TOTAL	\$134,267.48	\$73,140.70	\$27,944.54	\$19,679.21	\$345,580.64	\$24,059.68	\$61,625.25

\*Total includes: 103 - Psychologists' fees; 108 - Hospitalization.

Source: Data provided by the Office of the Ministry Chief Accountant.

TABLE 2

EXPENDITURES ON HEALTH SERVICES - TRAINING SCHOOLS  
Year ending March 31, 1972

## A. SUMMARY

	1. Salaries & wages 2. Employee benefits	4. Charges for services (including rentals)			3. Transportation and Communications	5. Supplies and equipment	1 - 7 Grand total**
		Personnel* services (fees)	Hospitali- zation (108)	Total charges			
Grandview	\$ 55,343.70	\$ 55,458.80	\$12,395.35	\$ 68,029.09	\$ 774.73	\$ 6,032.75	\$130,180.27
Trelawney House		2,564.90	33.00	2,597.90		473.71	3,071.61
Kawartha Lakes	25,415.52	14,867.85	451.80	15,576.29	5.15	4,731.26	45,728.22
Elmcrest	15,480.66	6,717.30	769.20	7,517.99	48.50	2,170.99	25,218.14
Pine Ridge	38,102.95	17,990.10	767.41	18,969.20	416.95	3,805.94	61,295.04
Brookside	42,804.29	6,346.25	707.90	7,342.79	690.45	2,487.33	53,324.86
Hillcrest	2,843.41	11,193.75	222.15	11,435.90		499.20	14,778.51
Glendale	25,645.91	7,641.60	345.50	7,998.96	2.00	1,126.87	34,773.74
Sprucedale	46,745.50	23,843.44	1,078.16	24,939.22	549.20	4,532.44	76,766.36
Cecil Facer	16,862.91	4,180.33	361.66	4,541.99	15.04	6,639.57	28,059.51
Portage Lake Camp		163.11	97.50	260.61	5.00	2,978.03	3,243.64
Wendigo Lake Camp						202.02	202.02
TOTAL	\$269,244.85	\$150,967.43	\$17,229.63	\$169,209.94	\$2,507.02	\$35,680.11	\$476,641.92

\*Includes 101, 102, 103, 105 and 106.

\*\*Includes 6 and 7 - both nil.

Source: Data provided by the Office of the Ministry Chief Accountant



TABLE 2

## EXPENDITURES ON HEALTH SERVICES - TRAINING SCHOOLS

Year ending March 31, 1972

## B. DETAILS OF EXPENDITURES

Training School	443xxx Personnel services					Total including 103. Psychol- ogists' fees, 108. Hosp- italization	560xxx Medical supplies, instruments, etc.. (value under \$100)	
	Doctors' fees 101	Psychiatrists' fees 102	Dentists' fees 105	Optometrists' fees 106			Dental supplies, instrum- ents, etc. 100	Pharmaceuti- cal and medi- cal supplies * 300
Grandview	\$ 8,745.05	\$39,433.00	\$ 5,406.00	\$1,874.75		\$ 67,854.15	\$1,618.82	\$ 2,932.95
Trelawney House	2,269.60			295.30		2,597.90		215.83
Kawartha Lakes	4,999.45	7,910.00	852.40	1,106.00		15,319.65	952.52	3,059.08
Elmcrest	1,460.00	2,237.00	2,825.00	195.30		7,486.50		1,842.10
Pine Ridge	6,603.25	8,940.55	1,256.30	1,190.00		18,757.51	1,465.51	1,849.42
Brookside	4,814.47	16.00	430.50	790.28		7,054.15	1,109.57	1,182.69
Hillcrest	5,227.00	2,770.50	2,864.00	332.25		11,415.90	8.00	201.68
Glendale	4,317.10	2,540.50	107.75	676.25		7,987.10	318.30	479.43
Sprucedale	6,461.74	15,165.20	85.00	2,131.50		24,921.60	464.60	3,413.04
Cecil Facer	130.00		4,040.33	10.00		4,541.99	2,986.44	2,887.41
Portage Lake Camp	68.00		61.00	34.11		260.61		1,914.53
Wendigo Lake Camp								
TOTAL	\$45,095.66	\$79,012.75	\$17,928.28	\$8,635.74		\$168,197.06	\$8,923.76	\$19,978.16

\*Plus 200 - Surgical Supplies, etc: Brookside \$1.90; Cecil Facer \$47.50; Total \$49.40.  
Source: Data provided by the Office of the Ministry Chief Accountant.



TABLE 3

HEALTH SERVICES PERSONNEL, SOCIAL WORKERS, PSYCHOLOGISTS AND PSYCHOMETRISTS<sup>1</sup>  
IN ADULT INSTITUTIONS (EXCLUDING JAILS)

Institution	Physicians		Psychiatrists		Dentists		Nurses		All health <sup>2</sup> services			Social <sup>3</sup> Workers		Psychol- <sup>4</sup> ogists		Psycho-metrists	
	FT	PT	FT	PT	FT	PT	FT	PT	FT	PT	Total	FT	PT	FT	PT	FT	PT
Vanier Centre for Women		1		3			1	5	2	5	7		4	1			
Burwash CC & ATC		1					1	1		1	2				1		1
Burwash CC	2					1		4		7	1		1		1		
Guelph CC & N.P.C.	2	2	1	1	1	1	8	2	15	5	20	5	3	1	3	1	1
Millbrook CC		1		1		1	1	1	1	4	5	1				2	
Mimico CC & A.G. Brown	1	2		4		1	3		4	7	11	6		5	2	3	
Monteith CC & ATC		3					1	1		1	4					1	
Rideau CC & ATC		1					1	1	1	2	3	2		1	1	2	
Thunder Bay CC & ATC		1					1			3	3				1		1
Brampton ATC		1		1			1	1	1	3	4	1		1		1	
Camps (not included above)		3								3	3						
TOTALS	5	16	1	10	2	8	25	4	36	41	77	20		11	7	13	2

1. FT = full-time; PT = part-time and includes persons on fees, sessional appointment, honorarium, etc.

2. Health Services totals include: Optometrists (PT) on fees - one each at Burwash, Millbrook and Thunder Bay;  
3 secretaries and typists (PT) at Guelph; vacant psychiatrist position (PT) at Vanier.  
See also Tables 21 & 22 (pp. 192,194)

3. Social Workers - All FT and includes one vacancy at Mimico.

4. Psychologists - Includes one PT (lecturer and teacher) at Guelph (staff training).

Source: Based on information provided by the Directors of Medical Services, Social Work and Psychology.

TABLE 4

HEALTH SERVICES PERSONNEL, SOCIAL WORKERS, PSYCHOLOGISTS AND PSYCHOMETRISTS IN TRAINING SCHOOLS<sup>1</sup>

Training School	Physicians PT	Psychi- atrists PT	Dentists PT	Nurses			All health <sup>2</sup> services			Social <sup>3</sup> Workers FT	Psychol- ogists		Psycho- <sup>4</sup> metrists FT
				FT	PT	PT	FT	PT	Total		FT	PT	
Grandview & R. & D. C.	1	2	2	5	1	1	6 <sup>2</sup>	6	12	5 <sup>3</sup>	1	1	3 <sup>4</sup>
Kawartha Lakes	1	1	1	3	1	1	3	4	7	1		1	1
Elmcrest	2	1	1	4			4	4	8	2	1		1
Trelawney House	1	1	1					3	3				
Brookside	1	1	1	3			3	3	6	2		1	1
Cecil Facer	1		1	3			3	2	5	3			1
Glendale	1	1	1	3	1	1	3	4	7	1			
Hillcrest	1	1	1		1			4	4	1			
Pine Ridge	1	2	1	3			3	4	7	2		1	1
St. John's	1	2	2	1	5	1	1	10	11	2 <sup>3</sup>	1		1
St. Joseph's	1	1	1	3			3	3	6	2	1		1 <sup>4</sup>
Sprucedale & White Oaks Village	1	2	1	3	1	1	3	5	8	4			
Project D.A.R.E.	2							2	2				
Oakville Centre										3			
TOTALS	15	15	14	31	10	32	54	86		28	4	4	10

1. FT = full-time; PT = part-time and includes persons on fees, sessional appointment, honorarium, etc.  
 2. Health Services totals include one PT secretary at Grandview. See also Tables 21 & 23, pp. 192 & 195.  
 3. Social Workers - All FT except one PT at Grandview; includes one vacancy at St. John's.  
 4. Psychometrists - All FT except one PT at St. Joseph's; includes one FT at Grandview on leave.

Source: Based on information provided by the Directors of Medical Services, Social Work and Psychology.

TABLE 5

APPENDIX 10  
(7)

AGE DISTRIBUTION OF HEALTH PERSONNEL  
Physicians, Psychiatrists, Dentists and Nurses

JAILS, CORRECTIONAL CENTRES AND TRAINING SCHOOLS

Year of birth	Age group yrs.	Physicians & psychiatrists			Dentists			Nurses			Total		
		FT	PT	T	FT	PT	T	FT	PT	T	FT	PT	T
1893-1897	75-79		2	2								2	2
1898-1902	70-74		4	4								4	4
1903-1907	65-69		6	6				1	1	2	1	7	8
1908-1912	60-64	1	7	8	1	1	2	6		6	8	8	16
1913-1917	55-59	1	3	4				9	2	11	10	5	15
1918-1922	50-54	2	2	4	2	1	3	8	1	9	12	4	16
1923-1927	45-49	3	8	11	2		2	6	2	8	11	10	21
1928-1932	40-44	1	3	4		3	3	9	4	13	10	10	20
1933-1937	35-39		4	4		1	1	2	2	4	2	7	9
1938-1942	30-34		10	10		2	2	9	2	11	9	14	23
1943-1947	25-29	1	2	3		1	1	7	1	8	8	4	12
Total		9	51	60	5	9	14	57	15	72	71	75	146
Unspecified			3	3				1	1	2	1	4	5
TOTAL		9	54	63	5	9	14	58	16	74	72	79	151

FT = Full-time

PT = Part-time (including those on fees, contract and sessional appointments)

T = Total full-time and part-time

Source: Health Personnel Inventory Forms

LENGTH OF STAY STUDIES

APPENDIX 11

TABLE 1

SUMMARY OF RESULTS FROM INMATE RECORD SAMPLE STUDY  
(with explanatory notes)

Type of institution	Total sample				Repeaters		
	No. (Inmate records)	%	Mean stay (average)		No.	Mean stay (average)	
			Days	Months		Days	Months
Jails	1,074	57.87	19.38*	0.65	87	20.57	0.69
Adult Training Centres	140	7.54	101.36	3.38	9	171.44	5.72
Correctional Centres	575	30.98	60.37	2.01	72	68.90	2.30
Forestry Camps	67	3.61	17.37	0.58	11	15.54	0.52
TOTAL	1,856	100.00	38.19	1.27	179	47.56	1.58

(179 Repeaters or 9.64% of sample)

Explanatory Notes:

- (1) The sample unit was the inmate record card maintained in Main Office for persons in jails and other adult institutions \*"whose sentences aggregate 15 days or more."
- (2) Stay = Time between date of admission and date of discharge; the former date was included, the latter excluded.
- (3) Two samples are combined in the above table; both were selected in July, 1972. Total sample - 1,856.
- (4) Sample 1 was a systematic sample consisting of every fourth record from 24 of the most recent drawers of records. Sample size - 994 inmates.
- (5) Sample 2 was a systematic sample consisting of every fourth record from 19 drawers selected so that 2 out of 7 drawers were sampled. (Third row of drawers from floor.) Sample size - 862 inmates.
- (6) This inmate record sample study was carried out by Mr. Andrew Pakula, assisted by Miss Grazyna Kwiatkowska, both of the University of Toronto team. (See Appendix 9, Medical Record Studies.)

Note - This work was carried out with the cooperation and assistance of Mr. G. Bond, Supervisor, Office Services, Financial and Administrative Services Division of the Ministry.



LENGTH OF STAY STUDIES

APPENDIX 11

TABLE 2

LENGTH OF STAY DISTRIBUTIONS FROM INMATE RECORD SAMPLE STUDIES\*

CORRECTIONAL CENTRES, ADULT TRAINING CENTRES AND FORESTRY CAMPS

Stay		Correctional Centres (9)	Adult Training Centres (5)	Forestry Camps	Total	Cumulative Total	Cumulative %
Days	Months						
1-30	1	221	21	60	302	302	38.62
31-60	2	189	36	7	232	534	68.29
61-90	3	48	19		67	601	76.85
91-120	4	49	17		66	667	85.29
121-150	5	21	18		39	706	90.28
151-180	6	9	11		20	726	92.84
181-210	7	7	2		9	735	93.99
211-240	8	17	5		22	757	96.80
241-270	9	5	4		9	766	97.95
271-300	10	3	5		8	774	98.98
301-330	11	1	2		3	777	99.36
331-360	12	3			3	780	99.74
361-390	13					780	99.74
391-420	14					780	99.74
421-450	15					780	99.74
451-480	16	1			1	781	99.87
481-510	17					781	99.87
511-540	18	1			1	782	100.00%
TOTAL		575	140	67	782		

\*See Appendix 11, Table 1, and Explanatory Notes.



LENGTH OF STAY STUDIES

APPENDIX 11

TABLE 3

LENGTH OF STAY DISTRIBUTIONS FROM INMATE RECORD SAMPLE STUDIES\*

JAILS

Stay		Jail Group						Total	Cumulative Total	Cumulative %
Days	Weeks	1	2	3	4	5 Hamilton	6 Toronto			
1-7	1	1	28	23	17	6	127	202	202	18.81
8-14	2	2	98	48	87	13	89	337	539	50.18
15-21	3	1	83	43	82	13	105	327	866	80.63
22-28	4	1	19	11	14	4	10	59	925	86.13
29-35	5		13	7	8	4	9	41	966	89.94
36-42	6	2	5	4	13		12	36	1,002	93.30
43-49	7	1	5	4	2	1	3	16	1,018	94.79
50-56	8		2	3	4	1	2	12	1,030	95.90
57-63	9		1	2	5	1	6	15	1,045	97.30
64-70	10			1	3		2	6	1,051	97.86
71-77	11		2			1	2	5	1,056	98.32
78-84	12			1	1			2	1,058	98.51
85-91	13		2		1		1	4	1,062	98.88
92-98	14		1	1	1			3	1,065	99.16
99-105	15						1	1	1,066	99.26
106-112	16			1				1	1,067	99.35
148-154	22		1		1			2	1,069	99.53
183-189	27			1				1	1,070	99.63
190-196	28			1				1	1,071	99.72
204-210	30						1	1	1,072	99.81
232-238	34						1	1	1,073	99.91
239-245	35						1	1	1,074	100.00
TOTAL		8	260	151	239	44	372	1,074		

\*See Appendix 11, Table 1, Note (1)

LENGTH OF STAY STUDIES

APPENDIX 11

TABLE 4

LENGTH OF STAY FROM MEDICAL RECORD STUDIES\*

A. DISTRIBUTIONS FOR FIVE INSTITUTIONS (QUEEN'S TEAM)

Length of stay (months)	Millbrook CC	Pine Ridge T.S.	Guelph CC	Length of stay (weeks)	Quinte RDC	Ottawa Jail
Under 1 month	6	4	30	Under 1 week	40	64
1 month	11	0	27	1 week	27	15
2 months	3	3	16	2 weeks	19	8
3 "	10	2	12	3 "	11	9
4 "	4	8	6	4 "	3	2
5 "	5	25	4	5 "	0	1
6 "	3	13	4	6 "	0	0
7 "	4	5	7	7 "	0	1
8 "	3	5	0			
9 "	2	1	4			
10 "	3	1	1			
11 "	1	0	2			
12 "	1	1	0			
13-12 months	2	0	2			
Total Inmates	58	68	115	Total Inmates	100	100

B. AVERAGE (MEAN) STAY

<u>Queen's University*</u>			<u>University of Toronto Team*</u>		
Ottawa Jail	1.3 weeks	(100)	Brampton Jail	21.75 days	(100)
Quinte R.D.C.	1.6 weeks	(100)	Toronto Jail - Males	8.20 days	(300)
			- Females	7.35 days	(100)
Millbrook C.C.	5.0 months	( 58)	Vanier C.C.	3.45 months	(100)
Guelph C.C.	3.2 months	(115)	Mimico C.C.	2.09 months	(267)
			Brampton A.T.C.	5.32 months	(100)
Pine Ridge School	5.2 months	( 68)	Grandview School	6.71 months	(100)
			Hillcrest School	8.37 months	( 69)

\*See Teams and Explanatory Notes, Appendix 9 (pp. 262-265)

Number of inmates or students in brackets.

BASIC DATA ABOUT JAILS

TABLE 1

APPENDIX 12  
(1)

AGE OF ONTARIO JAILS\*

	<u>No.</u>	<u>%</u>	<u>Cumulative %</u>
Built before 1872 - more than 100 yrs. old	25	58.14	58.14
Built 1872-1921 - 50-99 yrs. old	8	18.60	76.74
Built 1922-1951 - 20-49 yrs. old	6	13.95	90.69
Built 1952-1961 - 10-19 yrs. old	2	4.65	95.34
Built since 1961 - less than 10 yrs. old	2	4.65	99.99
<u>TOTAL</u>	<u>43</u>	<u>99.99%</u>	

TABLE 2

SELECTED POPULATION STATISTICS FOR JAILS BY GROUPS\*

DURING THE YEAR ENDED MARCH 31, 1971

<u>Item</u>	<u>Group</u> <u>6</u> (Toronto)	<u>Group</u> <u>5</u> (Hamilton)	<u>Group</u> <u>4</u>	<u>Group</u> <u>3</u>	<u>Group</u> <u>2</u>	<u>Group</u> <u>1</u>	<u>Total</u> <u>all jails</u>
1. Capacity	753	142	555	318	731	60	2,559
2. Avg. daily population	711	118	521	236	450	26	2,062
3. Total committed (plus lock-up and transit)	25,161	4,526	20,912	9,808	19,137	1,515	81,059
4. Total days stay	259,256	46,286	199,721	88,460	167,448	10,063	771,234
5. Avg. days stay (4/3)	10.30	10.23	9.55	9.02	8.75	6.64	9.51
6. % occupancy (100 x 2/1)	94.4	83.1	93.9	74.2	61.6	43.3	80.6
7. Distribution of committed - %	31.04	5.58	25.80	12.10	23.61	1.87	100.00
8. Dist. of days - %	33.62	6.00	25.90	11.47	21.71	1.30	100.00
9. Distribution of capacity - %	29.43	5.55	21.69	12.43	28.57	2.34	100.01
No. of jails in groups	1	1	7	6	23	3	41

\*Unless otherwise specified, data are from the Annual Report of the Minister for the year ending 31st March 1971.

BASIC DATA ABOUT JAILS

TABLE 3

APPENDIX 12

(2)

BASIC DATA ABOUT JAILS IN ONTARIO

For year ended March 31, 1971

(Annual Report 1971)

Group	Location	County or District	Built	Capacity (accommodation)			Population (Inmates)		
				Male	Female	Total	Maximum	Minimum*	Avg. daily
6	Toronto (Don)	York	1862	705	48	753	836	455	711
5	Hamilton	Wentworth	1875	124	18	142	163	84	118
4	Kenora	Kenora	1928	47	10	57	148	29	98
	London	Middlesex	1843	72	8	80	105	44	75
	Ottawa	Carleton	1862	116	16	132	114	37	90
	Sault Ste. Marie	Algoma	1914	32	7	39	61	17	36
	Sudbury	Sudbury	1928	59	9	68	112	35	84
	Thunder Bay	Thunder Bay	1923	64	13	77	97	30	68
	Windsor	Essex	1925	92	10	102	90	42	70
3	Barrie	Simcoe	1843	45	7	52	55	11	33
	Kitchener	Waterloo	1853	34	5	39	56	19	40
	St. Catharines	Niagara North	1866	60	8	68	72	17	40
	Sarnia	Lambton	1961	44	10	54	58	18	35
	Welland	Niagara South	1856	45	6	51	53	10	34
	Whitby	Ontario	1958	40	14	54	71	28	54
2	Brampton	Peel	1867	32	2	34	59	22	38
	Brantford	Brant	1852	46	3	49	44	5	23
	Brockville	Leeds & Grenville	1842	24	4	28	24	2	17
	Chatham	Kent	1850	31	5	36	47	14	28
	Cobourg	Northumberland and Durham	1906	35	3	38	30	8	19
	Cornwall	Stormont, Dundas & Glengarry	1833	17	3	20	33	8	17
	Fort Frances	Rainy River	1907	10	2	12	23	3	11
	Guelph	Wellington	1853	28	-	28	34	11	20
	Haileybury	Temiskaming	1923	29	3	32	41	17	27
	Lindsay	Victoria and Haliburton	1863	30	6	36	31	5	15
	L'Orignal	Prescott and Russell	1828	24	3	27	18	2	7
	Milton	Halton	1878	29	3	32	31	6	20
	Monteith	Cochrane	1965	23	-	23	29	4	14
	North Bay	Nipissing	1928	59	9	68	63	14	32
	Owen Sound	Grey	1869	28	2	30	34	10	23
	Parry Sound	Parry Sound	1878	32	4	36	42	10	22
	Pembroke	Renfrew	1866	24	8	32	36	7	17
	Peterborough	Peterborough	1866	18	6	24	46	19	31
	St. Thomas	Elgin	1853	17	4	21	32	7	18
	Simcoe	Norfolk	1851	31	3	34	35	3	14
	Stratford	Perth	1887	22	4	26	27	2	11
	Walkerton	Bruce	1866	28	4	32	31	3	12
	Woodstock	Oxford	1853	28	5	33	25	1	14
1	Cayuga	Haldimand	1851	12	6	18	17	-	7
	Orangeville	Dufferin	1881	18	-	18	20	-	6
	Perth	Lanark	1864	18	6	24	25	2	13

\*Minimum or least number is for male inmates; generally, the least number of females was zero or 1 except for Toronto 16, and Kenora 11.



BASIC DATA ABOUT JAILS

TABLE 4

APPENDIX 12

(3)

JAILS - OCCUPANCY, DAYS STAY AND INMATE LOAD

For year ended March 31, 1971

(Annual Report 1971)

Group No.	Location	Total committed	Total days stay	Avg. days stay	% Occu-pancy*	Distribution %	
						Committed	Days
6	Toronto (Don)	25,161	259,256	10.30	94.4	31.04	33.62
5	Hamilton	4,526	46,286	10.23	83.1	5.58	6.00
4	Kenora	3,186	35,649	11.19	171.93	3.93	4.62
	London	3,144	29,391	9.35	93.75	3.88	3.81
	Ottawa	4,152	35,897	8.65	68.18	5.12	4.65
	Sault Ste. Marie	1,520	13,066	8.60	92.31	1.88	1.69
	Sudbury	3,962	35,145	8.87	123.53	4.88	4.56
	Thunder Bay	2,974	24,826	8.35	88.31	3.67	3.22
	Windsor	1,974	25,747	13.04	68.63	2.44	3.34
3	Barrie	1,649	12,877	7.81	63.46	2.03	1.67
	Kitchener	1,468	14,647	9.98	102.56	1.81	1.90
	St. Catharines	2,025	15,192	7.50	58.82	2.50	1.97
	Sarnia	1,647	13,474	8.18	64.81	2.03	1.75
	Welland	1,293	12,442	9.62	66.67	1.60	1.61
	Whitby	1,726	19,828	11.49	100.00	2.13	2.57
2	Brampton	1,503	13,901	9.25	111.76	1.85	1.80
	Brantford	1,106	8,295	7.50	46.94	1.36	1.08
	Brockville	864	6,136	7.10	60.71	1.07	0.80
	Chatham	1,253	10,245	8.18	77.77	1.55	1.33
	Cobourg	929	6,725	7.24	50.00	1.15	0.87
	Cornwall	901	6,531	7.25	35.00	1.11	0.85
	Fort Frances	469	3,938	8.40	91.67	0.58	0.51
	Guelph	722	8,114	11.24	71.43	0.89	1.05
	Haileybury	397	9,904	24.95	84.38	0.49	1.28
	Lindsay	1,266	6,906	5.45	41.67	1.56	0.90
	L'Orignal	382	2,739	7.17	25.93	0.77	0.36
	Milton	964	6,988	7.25	62.50	1.19	0.91
	Monteith	664	6,110	9.20	60.87	0.82	0.79
	North Bay	1,471	11,539	7.84	47.06	1.81	1.50
	Owen Sound	804	8,519	10.60	76.67	0.99	1.10
	Parry Sound	680	8,177	12.02	61.11	0.84	1.06
	Pembroke	809	6,356	7.86	53.12	1.00	0.82
	Peterborough	1,026	11,314	11.03	129.17	1.27	1.47
	St. Thomas	624	6,625	10.62	85.71	0.77	0.86
	Simcoe	810	4,979	6.15	41.18	1.00	0.65
	Stratford	428	3,980	9.30	42.31	0.53	0.52
	Walkerton	589	4,413	7.49	37.50	0.73	0.57
	Woodstock	476	5,014	10.53	42.42	0.59	0.65
1	Cayuga	403	2,751	6.83	38.89	0.50	0.36
	Orangeville	375	2,381	6.35	33.33	0.46	0.31
	Perth	737	4,931	6.69	54.17	0.91	0.64
41 Jails		81,059	771,234	9.51	80.60	100.00	100.01

\*Average daily population as % capacity (Table 2, P.293)



REPORT OF THE NURSING CONSULTANT  
TO  
THE COMMITTEE TO STUDY  
HEALTH SERVICES IN THE ONTARIO  
MINISTRY OF CORRECTIONAL SERVICES

Presented to

E.H. BOTTERELL, M.D.

by

Shirley L. Smale, R.N., M.P.H.

August 12, 1972

REPORT OF THE NURSING CONSULTANT TO  
THE COMMITTEE TO STUDY HEALTH SERVICES  
IN THE ONTARIO MINISTRY OF CORRECTIONAL SERVICES

1. INTRODUCTION

1.1 Terms of Reference

The nursing consultant was appointed to assist the committee studying the health services of the Ontario Ministry of Correctional Services. The designated purpose of reviewing nursing within the system was to supply the committee with an account of the nursing services and working conditions of nurses, and to make recommendations related to the possible future role and training of nurses for the health programs of the Ministry.

1.2 Purpose of the Report

The expressed purpose of this report is to discuss the present functioning of nurses in the system and to identify the possibilities, where indicated, for altering and/or upgrading the role of nurses. The consultant attempted to limit her report to matters which were directly related to or which had consequences for nursing services, leaving discussion of other aspects of the health services to those whose task it was to report on them.

1.3 Institutions Visited; Nurses Consulted or Observed

Observations were made in a total of eighteen institutions illustrative of the health services of the various types of correctional

institutions in Ontario, with the exception of camps.<sup>1</sup> Jails, training schools for wards of the superintendents, adult correction centres, and adult training schools, and the two major treatment clinics, the Neuropsychiatric Unit at Guelph and the A.G. Brown Clinic at Mimico, were visited. Of approximately eight-two nurses in the Ministry,<sup>2</sup> fifty-six were employed in the eighteen institutions visited. Of those, thirty-three were observed or consultation held with them, in some instances when the physician was present and at times when he was not.

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<sup>1</sup> See Table I, Appendix A, Page 36.

<sup>2</sup> Nominal Role, Medical Services Branch, Ministry of Correctional Services, March, 1972.

## 2. FINDINGS

### 2.1 General Comments about Nursing Services and the Conditions of Nursing

#### 2.11 Minimal to Moderately Adequate Nursing Service

It was this consultant's judgment that under the conditions observed in these settings, in which health care enjoys little visibility and status, nursing services to the residents of the correctional institutions ranged from minimal to moderately adequate.

#### 2.12 Nurses Providing Major Portion of Health Care Services Delivered

It became apparent, early in the visits that:

2.121 nurses were providing the major volume of the general health services delivered, and

2.122 an uneven distribution of nursing services existed among the various types of correctional institutions apparently without any accompanying rationale.

#### 2.13 Disparities in Nursing Services Provided

There was disparity in the nursing services provided in the various kinds of institutions. The disparities related to level of responsibility and scope of services expected of the nurses. Many facets of the nurses' work did not bear much relevance to the nature of the nursing services required in the institutions observed.

## 2.14 Professional Isolation, Dearth of Nursing Direction and Professional Frustration

Of interest to the consultant was the fact that despite the professional isolation, dearth of direction and supervision observed and in the absence of the usual professional incentives and satisfactions, a few individual nurses were seen to approach their work in an imaginative way. The head nurse at Vanier Centre exemplifies the above point. However most nurses consulted were found to be skeptical about the possibility of positive change occurring. They communicated feelings of professional frustration, hopelessness, helplessness, and isolation about the health services and their working conditions. Those who stated they had attempted to bring about change were ultimately as discouraged.

## 2.2 Administrative Considerations in Relation to Nursing

The current conditions of the system's health services organization and administration have significant consequences for the nursing services. Many problems were observed, others came to light out of conversations held with the staff. These problems and their impact on the nursing services are summarized below:

### 2.21 Lack of Nursing Administration or Nursing Consultant

There was no qualified person, such as a nursing administrator or consultant, either within or outside the system;

a) to help shape nursing service policy, and b) to lend direction



and support to the nurses in the individual health services of the institutions.

## 2.22 Central Medical Services Administration

The central medical services administration appeared to lack strength, autonomy and administrative skills and for these reasons, among possible others, demonstrated limited ability to represent and support the interests of health care within the organization in general. In particular, the health services of the local institutions were seriously handicapped.

## 2.23 Administration of the Health Program of Adult Institutions and Training Schools

In each institution the medical officer was held responsible to the superintendent for the administration of the health program of an adult institution or training school under their respective Acts and Regulations, The Department of Correctional Services Act, Revised Statutes of Ontario, 1970, 110 as amended by 1971, Chapter 50, s. 27, October, 1971 and The Training Schools Act, Revised Statutes of Ontario, 1970, Chapter 407, October, 1971. Understandably, physicians and nurses in the health services lacked administrative skills, since many of them had never received training in that area. The medical officer was in the institution for short periods and often infrequently and the task of administering the health services was often delegated to the nurse. Nurses were able

to identify and analyze the administrative problems quite accurately in some instances but did not know where to go from there for help in dealing with them.

#### 2.24 Organization of Health Services Related to Functioning of the Nursing Program

The organizational structure of Health Services failed to clarify the administrative relationships and arrangements within the health care system so that lines of authority and accountability were vague, thus poorly understood and utilized by nurses. This caused much confusion to the nurses since they were unsure as to whom to direct certain matters, from whom to expect and accept professional direction in their work, and at times, unsure of what it was they should be doing. Among the administrative arrangements and relationships requiring clarification are:

2.241 Those arrangements concerned with: lines of authority; autonomy of program; and professional (clinical) autonomy, direction and accountability.

2.242 Those relationships between: the (central) medical director, the superintendent, the physician and the nurse with respect to administrative and clinical direction and accountability.

The consultant believes the above issues to be of central importance

since they have direct implications for programming and developing the nursing component within the health service and for recruiting and holding qualified staff.

#### 2.25 Lack of Communication Between General Health Service Nurses and Psychiatric Service Nurses

The lack of communication between the nurses providing the general health services and those employed in the psychiatric areas was also of central importance. Expertise within these two groups of nurses was not shared even when they were both working in the same institution. By and large the nurses' behaviour appeared to reflect that of their physician colleagues, who tended to overidentify with a particular clinical area in place of looking at the residents' or group' health problems more completely. When there were both general health services and a psychiatric service offered in the same institution they were administered as separate services. The arrangement tended to fracture the health services even more.

#### 2.26 Opportunity for Multidisciplinary Planning for Health Care Not Taken by Professionals

Also apparent was a general lack of joint planning and communication between the several disciplines interested in the residents' health and rehabilitation (medicine, nursing, psychology, psychiatry, social work, teaching, classification, placement and aftercare personnel, and others from the

correctional staff). In the institutions observed to be using a multidisciplinary approach there appeared to be a more creative and committed staff. The Vanier Correction Centre has the kind of working relationships which exemplify a cooperative approach to rehabilitation. Nursing staff at the Vanier Centre reported that they found the increased communication and joint planning to be a satisfying professional experience. One might ask whether a goal of increased, appropriate multidisciplinary operation could not serve the rehabilitation goals quite well, and if so, what alterations could be made administratively to help achieve this end?

## 2.28 Security Measures Related to Nursing Care

The nature of the security measures as these relate to several aspects of the nursing service require some comment. Those of greatest concern include:

### 2.281 Confidential Nurse-Patient Conversation Related to Physical Facilities

The confidential nature of the nurse-patient relationship: There appeared to be few if any facilities established where the nurse could retain verbal and auditory privacy in conferring with the inmate or student yet be in full view of the correctional officer if this was required for security or safety reasons. It became immediately apparent that patients were unable to enter

into a confidential professional relationship with the nurse when other staff were physically present.

2.282 Personal Privacy of Inmate or Student  
When Receiving Health Care

Denial of the individual's need for privacy when he was receiving health care appeared to have dehumanizing and humiliating consequences and may have tended to dilute the therapeutic effects of the health service contact. Violation of a person's privacy may have consequences in terms of the individual's future respect and trust of the health services.

2.3 Conditions of Work and Employment of Nurses

Although several circumstances of consequence to nurses and their professional performance, status, and job satisfaction have been referred to or were implied in the preceding section, others of direct impact will be discussed here. Included in this group are:

2.31 Lack of Professional Clinical Direction  
and Support

Lack of nursing direction, supervision, and encouragement for the work carried out were reflected almost unanimously by nurses making statements referring to such items as "professional isolation", requests for "clinical assistance" to increase their capacity and skill, and statements regarding the fact that there is "no one up there to speak to" or "on behalf



of the patients' nursing care needs", nor for that matter, for the "needs of the nursing group".

#### 2.32 Professional Incentives and Opportunities for Nurses

Included in the "needs of the nursing group" were those of incentives and opportunities (with the sanction and support of the institution) encompassing financial assistance and support from the organization for further training or study; or if this was not possible, other forms of support and sanction which would indicate the organizations' interest in the professional work of the individual.

In pursuing educational and training opportunities, which ultimately increase their clinical competence, nurses look to the organization to promote, support and help finance this type of professional development. Inservice education of a multidisciplinary nature, within the Ministry, so far as could be observed, was only beginning. Nurses were infrequently consulted regarding overall inservice educational planning, at both the divisional and institutional levels, and were rarely included in the planning groups, according to the staff nurses who reported on this.

#### 2.33 Professional Upgrading Through Education and Professional Consultation

It is clear that provision for nurse training and other types

of professional upgrading should be made available for this group of employees. Nurses should be encouraged to take advantage of the educational experiences available to them. The extent of professional isolation is illustrated in the fact that for many of the nurses visited, some of whom had been with the organization for five to over ten years, this consultant was the first professional nurse who had conferred with them in an official capacity either from within the Ministry or outside of it.

2.34 Nurses Require Orientation to the Ministry  
of Correctional Services and to the  
Health Services of the Ministry

Nurses stated, in most instances, that they would have been better prepared to function within the system had they been provided with a thorough initial orientation to the policies and to some of the general aspects of the Ministry's programs. They would have appreciated more detailed orientation to the health services aspects of the operation of the Ministry and specifically to the institution and the health service in which they were to be employed. In general, nurses were found to be poorly informed about the system in which they worked. The Ministry would benefit from ongoing education of the eighty-two nurses with regards to the goals of the Ministry as well as initial orientation to the health program.

2.36 Persons Other than R.N., R.N.A. Listed  
as Nurses<sup>1</sup> and Nurses Given Position  
Specification Other Than Nurse

Several discussions about job specifications led the nurse consultant to believe that nurses were employed under position titles other than "nurse" or "registered nurse", for instance, "health service attendant", or a similar title was seen to have been used. Observed also was the fact that nursing staff were not evaluated by a qualified nurse in relation to their professional performance and work attitudes. It is difficult to estimate what work-oriented criteria other than professional performance could be used as a basis for making decisions regarding continuation of employment, promotion, and salary increase, work responsibility and limitations, or on the other hand, decisions regarding severance from employment.

Significant to the consultant was the fact that in almost all instances nurses did not know to whom they could go for interpretation and assistance with personnel matters.

2.4 Nursing Staffing Arrangements in Jails,  
Adult Correctional Centres, Adult Training  
Centres, Training Schools for Wards and  
Psychiatric Units/Clinics

Staffing including the "on-call" system illustrated further disparity. No rationale emerged which logically equated numbers of

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<sup>1</sup> Nominal Role, Medical Services Branch, Ministry of  
Correctional Services, March, 1972.

nurses employed in a given institution, nor its staffing pattern and "on-call" system with the residents' needs for nursing service.

2.41 Jails: Distribution of Nursing Staff<sup>1</sup>

Jail staffing varied widely from no nursing service in thirty-nine of the forty-three jails to eleven nurses (full and part-time) in one large jail, and one nurse each in three other large jails employing nurses. A jail representing one of the top four in total inmate days in 1971 had no place in its establishment for either a part-time or full-time nurse.<sup>1, 2</sup>

The services provided by nurses differed very little in the jails. Related to the size of the jail was the volume of patients requiring admission physical examinations and physical examinations preparatory to transfer from the jail to another correctional institution, and the proportionate number attending sick parade and requiring medications. The jail having eleven nurses assigned to it was the only jail with a nurse or nurses on each of the three eight-hour tours of duty. In this same jail nurses were also assigned to specific areas such as the women's section and the psychiatric unit.

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<sup>1</sup> Nominal Role, Medical Services Branch, Ministry of Correctional Services, March, 1972.

<sup>2</sup> Report of the Minister (Ministry of Correctional Services), 1971.

2.42 Adult Training Centres, Adult Correction Centres:  
Distribution of Nursing Staff<sup>1</sup>

The thirteen adult correctional centres, adult training centres and psychiatric units or clinics employed twenty-six nurses.<sup>2</sup> Again numbers of nurses employed in these institutions varied considerably without any apparent predetermined method of allocating staff.

The six correctional centres and adult training centres visited<sup>3</sup> had nursing staffs which ranged from nine nurses in one of the largest centres to seven in another, three in three and only one nurse in one centre. The population of the latter institution had major security problems.

2.421 Nursing Staff Related to Size and Type of Institution

Some of the centres had a nurse or nurses for all three eight-hour tours of duty while other centres had nurses for either one or two tours of duty. No observable difference in the nursing program was identified in these adult centres with the exception that their sizes varied considerably and like the jails, size was reflected in the numbers requesting and requiring care.

2.422 Nursing Staffing Related to Continuity of Nursing Service

There was either no method to cover nursing services or the methods for dealing with staffing were awkward or

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<sup>1</sup> Nominal Role, Ministry of Correctional Services, March, 1972.

<sup>2</sup> Ibid.

<sup>3</sup> Appendix A, Page 36.



inadequate. Many adult institutions did not appear to have part-time or backup registered nursing staff of either sufficient numbers or with adequate knowledge about the institution so that they might assume the nurse's role and maintain continuity of nursing service. Large gaps in adequate coverage were observed in some adult institutions. In most institutions correctional staff were required to assume the health service responsibilities.

#### 2.423 Nurses and Forensic Psychiatry

No evidence was found to indicate that nurses were expected to engage in psychiatric counselling, especially in the A.G. Brown Clinic and the adult correction centres of medium or maximum security. Again, no evidence could be found either of inservice education specifically directed to nurses functioning in forensic psychiatry or of the employment of nurses prepared in psychiatric nursing.

#### 2.244 Staffing for Infirmary or "Hospital" Care in Sick Parade

In most of the correction centres observed there were a few "infirmary-type" service beds located in areas designated as "hospitals". In some places a correctional officer and an inmate-orderly covered the service from the mid-afternoon until midnight. The inmates in the infirmary were observed periodically, throughout the night by a correctional officer

on duty in that part of the institution. In other large centres observed a nurse or nurses were on duty all three tours of duty. There seemed to be no difference in "need" as one heard about the kinds of resident problems. In many correction centres where a second nurse was employed the nurses covered the institution from 6:30 or 7:00 a.m. until 9:00 or 10:00 o'clock at night. Their primary functions seemed to include dispensing the late afternoon and bedtime medications and doing whatever dressings or treatments and first aid that might be required. Some nurses held sick parade in the evening and others not. In some institutions at least one nurse would be involved in the infirmary care either supervising inmate-orderlies or providing care herself.

Since the day begins very early, tours of duty usually begin at 6:30 or 7:00 a.m. in the centres. Five or six hours later, a number of additional sick parade requests had emerged. The nurse, besides seeing these residents would be expected to assist the physician with admission and "transfer out" physical examinations, follow-up appointments and to carry out other activities related to obtaining data on inmates and otherwise seeing to their care. Each day the nurse visits inmates in segregation and detention cells.

#### 2.43 Training Schools for Wards: Staffing

Training schools regularly had three or four nurses assigned

to them. Often one nurse worked days and a second evenings, the evening nurse worked from 12 noon until 8:00 p.m. or from 2:00 to 10:00 p.m. These particular arrangements were made in order to cover the wards until "they were in their cottages for the night". The evening nurse in the schools, much as the nurse in the adult centres, may hold sick parade but otherwise dispensed medications at dinner time and bedtime and in addition carried out necessary treatments and first aid. Other staff worked part-time and relieved regular staff for days off and other absences. Some schools employed up to six nurses. In one of the schools three nurses worked in psychiatry exclusively while in the second school three persons categorized as nurse<sup>1</sup> were in effect combined nurse aide-clerks and child care workers.

#### 2.44 Staffing Patterns and Professional Satisfaction

Staffing patterns which represented several rotations from one shift to another over a week's period of time and which, therefore, required a rapid adjustment on the part of the individual employee may result in employee fatigue and lowered job performance. Some institutions observed, in which the above pattern existed, neglected to consider those aspects of staff needs. In general, staff were not in favour of such rapid rotation of the tour of duty for the reasons already referred to but in addition

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<sup>1</sup> Nominal Role, Medical Services Branch, Ministry of Correctional Services, March, 1972.

because of social-recreational, educational, and family interests. Poor planning, and inadequate numbers of relief and backup nursing staff required one of the largest and busiest institutions to have the nurse stay on for a double tour of duty.

#### 2.45 Deficits in Staff Planning in All Types of Institutions

The discussion of nursing staffing in the above section of the report (2.4), does not provide an adequate picture of the nursing services since some nursing staff are not registered nurses. Many nurses are part-time employees who may work regularly as relief personnel for days off, staff illnesses, vacations and so on while some are on a stand-by and "call as is needed basis". Although some institutions may have an adequate staffing pattern others appear to manage from day to day with no real evidence of overall staff planning.

In the jails in which there were no nursing services, the correctional staff or the physician performed some of the activities which otherwise would fall to the nurse. Correctional staff do not have the training to fulfill nursing responsibilities. Schools in general appeared to have a rather high ratio of nursing staff to population served but the fact that the school population represents heightened periods of growth and development and the health problems associated with them, may place an additional burden on the health services.

## 2.5 Handling of Emergency and Urgent Health Problems When Professional Health Staff are Not in the Institution

Generally an "on-call" system operated in each institution. Depending on the involvement of the physician and the number of nurses available, a verbal, or in some instances an agreement written into the job specification set the expectation for nurse responsibility for being "on-call". In the majority of instances the arrangement was one where the correctional staff, in the event that they recognized an urgent or emergent medical problem in an inmate or student, would contact the nurse first. The nurse would either come to the institution or depending on her evaluation of the severity of the situation, would direct the correctional staff to remove the resident to a hospital. The nurse might either call the physician herself or have the correctional staff do so for more definite directions in a given situation.

### 2.51 Policy Regarding Handling of Urgent or Emergency Medical Care Problems

There was no standardized method of dealing with the various categories of ill health in the absence of the nurse or physician.

a) In the jails in which there were no nurses employed, the correctional staff usually called the physician directly on the basis of their judgment of the severity of the problem. b) Jails, training schools, and adult correction centres with nurses usually preferred to call the nurse initially as a first line for screening.

In several instances references were made to the nurse



going over to the institution and evaluating a situation in order to determine whether the physician was required.

Local institutions may require considerable assistance in order to arrive at a plan for emergency care which meets the needs of a particular institution and its circumstances. Currently there is no data available upon which to evaluate the efficiency of the system relative to obtaining emergency services and health advice when the health service staff are not in the building.

## 2.6 Nurse Activity and Inmates' and Students' Utilization of Nursing Services

It was the consultant's opinion that while nurses usually appeared to be busy, much of their activity was the result of performing functions which could have been carried out by other types of staff, were they available. While some of those activities were referred to or required of the nurse by others some appeared to be self-selected by the nurse. Perhaps the latter occurred because nurses enjoyed performing certain activities. Several exceptions to the above were observed in some of the institutions where nursing staff was performing at an acceptable and adequate level, for instance in the general health service at the Vanier Correctional Centre.

### 2.61 Nurse's Role: Supporting, Interpreting to Inmates and Students

The nurse's role varied considerably from one institution to another and between the various kinds of institutions. Nurses were unsure about how far they should or could go in performing certain

activities and very likely with additional guidance could have been functioning somewhat more effectively than they were. Nurses employed in female institutions and in all institutions serving first offenders and wards reported that the inmates and students looked to nurses for support and counselling relative to the anxiety generated by the new experience, and for interpretation about the role of the health service and the nurse's role within it.

#### 2.62 Lack of General Agreement on Scope of Nurse's Role

There was little common understanding and agreement concerning the scope of nursing practice in the Ministry. Physicians tended to interpret the nurse's role in a limited way, as did the majority of nurses themselves. Resultingly, nursing services were often confined to dispensing medications, carrying out a few physical measurements which did not require clinical judgment, acting as first aid officers and performing other tasks which did not require their special skills and knowledge. In some instances either because the nurse was able to interpret her service to the physician or otherwise generate his support, or in those instances where he was infrequently available and may not have demonstrated interest, the nurse was seen to have moved ahead and to be performing a much broader service.

#### 2.63 Agreement Needed to Change Scope of Nurse's Role

The consultant judges the nurse of today to be fully capable

of playing a responsible and expanded role in health care to the advantage of the residents. Such a role would be in keeping with current nursing and medical practice. In order to provide broader services by a nurse, necessary administrative changes must be made; the nurses must be appropriately trained and supervised in their practice; the licensing bodies for physicians and nurses; the medical and nursing professions and the individual physicians and nurses must agree on the area of practice acceptable to them.

#### 2.64 Lack of Housekeeping Support Services for the Health Programs, Clerical and Other

A summary of the wide variety of activities currently being performed by nurses may be seen in Appendix B, page 38. In most instances nurses carried out only a modest portion of the activities listed in Appendix B. They were more frequently observed performing such activities as: clerical, porter, house-keeping, first-aid, dental assistance and x-ray technician.

Apparently no one else was available to carry out these activities which generally are inappropriate for nurses. In many settings nurses simply preferred to see these as appropriate nursing tasks. In one institution the segregation area had been constructed within the health service complex in order that inmates in segregation could be checked by nursing staff at frequent intervals. Nurses also complained about the large amounts of clerical work involved since directives, reports, and other types of communication

were required to be produced, sometimes with several copies. In few of the health services observed were there full or part-time clerical assistance for the health services.

## 2.65 Nursing Care Needs Arising From the Nature of the Correctional Setting

Of interest are the particular needs which could be stated to arise out of the nature of the setting.

### 2.651 Some Characteristics of Jails

Jails have a rapid turnover. Therefore, once the initial contact is made at the time of the admission physical examination, the inmate may not be available for further nursing services, including follow-up care. It follows that good communication using the available record system (9801-02) and other means of transferring information should be developed as fully as possible. In large jails the requirements for assistance at physical examination and distribution of large amounts of medication generally precluded the nurses from becoming involved in other professional activities with inmates.

The large volume dictated a type of care which was observed to be hurried and frequently rather impersonal.

### 2.652 Some Factors Associated with Subsequent Health Service Utilization

Requests for services, following the initial physical examination, may be frequent due to a number of factors

associated with the inmate and his particular situation:

- a. increased anxiety in response to the new surroundings and circumstances the inmate or student is experiencing.
- b. aggressive behaviour against one another and against self.
- c. retaliation at the institution through requesting health service frequently.
- d. boredom and the diversion a visit to health service brings.
- e. actual illness.
- f. usual pattern of high health service utilization as when he is "on the street".
- g. non-medical reasons for which inmates must receive sanction of the physician or nurse; shampoo, hair oil, etc.
- h. institutional policy regarding health service contact with persons in protective custody, segregation, detention and so on. This ranges from once a day to several times a day.

#### 2.653 Training School's Use of Health Services

Utilization of nursing services by the younger residents such as students housed in the various training schools appeared to reflect the supervisor's and teacher's interpretation of the purposes of the health services. In some instances where that understanding was consistent with acceptable health practices the health services were utilized in a reasonable fashion, but even when they were not, student utilization seemed to approximate "read need" more often than the "perceived needs" of the adult in the system.



## 2.66 History, Physical Examination, and Recording

The screening procedures and use of record forms (9801-02) varied widely from one part of the system to another, so that one could not be reasonably assured that a resident did indeed have certain basic screening procedures carried out or if he had, that they would be recorded on the medical status summary sheet.

## 2.67 Continuing Comprehensive Health Care for Wards of Training School who are in Placement

### 2.671 Provision for continuous primary health care

Maintenance of chronic illnesses and care in acute illness situations for wards, who although not attending one of the systems' schools remain wards in placement, represents a large number of students whose health care must be assured. For instance there were 1,379 students on the school roll on March 31, 1971.<sup>1</sup> At the beginning of that year (April 30, 1970) there were 2,550 under supervision on placement.<sup>2</sup> An additional 2,176 wards were placed in the succeeding twelve month period.<sup>3</sup> The health supervision and health care of this large group of children and youths, since they are wards of the training schools is the responsibility of the Ministry. Nurses in the system were not sure of what provisions or arrangements were in effect

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<sup>1</sup> Ontario Department of Correctional Services, Report of the Ministry, 1971, Training Schools, pp. 28, 29.

<sup>2</sup> Ibid., pp. 28, 29.

<sup>3</sup> Ibid. pp. 28, 29.

to assure wards adequate health care while in placement.

In general, nurses tended to identify with the immediate health concerns within the institution and had not looked to provisions past that.

2.672 Continuing Health Care for Adults: Parole,  
Completion of Sentence, and Bail, etc.

The immediate health care needs of persons released from jails or adult centres who may be only partially through a treatment regime or who may have chronic illness needs requiring long term follow-up, also demand attention. Nurses could be effective in interpreting community services and continuing care needs to these groups of adults and in referring them to community agencies such as the V.O.N., public health nursing services and clinics, or in helping them to follow the referral procedures for obtaining the services of private physicians. Some have O.H.I.P., which remained valid while they were serving their sentence, others require instruction about reactivating it. These and many other types of services could conceivably become a part of the nursing care responsibilities within the correctional system.

2.68 Environment: Adequacy of Healthful Living Conditions  
in Jails and Adult Correctional Centres

Environmental health is usually considered a special health concern quite apart from personal health care, and left to the

system's inspector or assigned to a health unit official.

In most of the jails and adult correctional centres visited (male), and with few exceptions, the environment was not conducive to healthful living. There were several examples of deficits.

2.681 Living Accommodations

In living accommodations, walls and floors were dirty; in some instances plaster, tiles, and other surfaces were falling off the walls; the furniture was broken; materials in mattresses could not be easily cleaned and in some instances, mattresses were not fireproof.

2.682 Bathing, Toileting Facilities

Toilets, handwashing, and shower facilities appeared dirty and in poor repair. In some instances, the ratio of these facilities to the numbers expected to use them should be reassessed.

2.683 Ventilation

Ventilation was poor in some of the older facilities. This is especially important for staff and inmates confined to areas such as segregation, protective custody and detention, and to staff and inmates in the kitchen, hospital, gymnasium, garage, shops and industrial areas.

2.684 X-ray Machines

X-ray machines in many institutions were poorly

maintained and could be a direct hazard to staff and inmates/ students exposed to them. Staff were not consistently trained to use the x-ray equipment and were not supervised.

2.69 Health Care Facilities Generally Inadequate

Health services were housed in facilities which, for the most part, were ill designed to meet the ambulatory nature of most of the work. Space in some institutions which is currently either not being used or in which infrequently utilized hospital beds are located could be redesigned to meet, to some extent, present needs for ambulatory care.

### 3. RECOMMENDATIONS

It is the nursing consultant's opinion that it would be in the interest of the Ministry to upgrade and to extend the functioning of nurses in its health services. However, it can not be assumed that changes in the nursing service program alone, without the other necessary and supportive changes required in the system, would in the long run improve the overall health care of residents. It is hoped that the above thoughts will be kept in mind in reviewing the nursing consultant's recommendations since it is essential that they relate to the overall findings and recommendations of the committee.

The following recommendations are made in response to the administrative, clinical, nursing and staff development issues which have been elucidated in this report.

The recommendations acknowledge recent changes in the role of the nurse in the provision of health care as stated in the Report of the Ontario Council of Health, 1970 and another more recent report the Report of the Committee on Nurse Practitioners, 1972. These reports advocate and support an extended role for the professional nurse and also suggest alternative methods for educating nurses for extended roles.

That pilot programmes of training for the nurse-physician assistant be established within health sciences complexes to capitalize on available clinical, educational and research resources.<sup>1</sup>

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<sup>1</sup> Report of the Ontario Council of Health, Supplement No. 3, 1970, Health Manpower, Recommendations, Page 4.



The Committee recommends:

- 1) That the multidisciplinary health team concept be implemented in order to improve the accessibility, comprehensiveness, co-ordination and personalization of health services, especially at the primary care level.
- 2) That nurses integrated thus into multidisciplinary teams, as nurse practitioners functioning in an expanded role (as outlined in the body of this report), bring their specific contributions to bear to make the team concept a reality.
- 6) That, until changes in basic nursing education are reflected, candidates interested in a career as nurse practitioners receive special preparation through supplemental programs of a formal nature in educational institutions affiliated with the university health sciences centre.
- 7) That the development of these supplemental courses be undertaken conjointly by faculties of Medicine and of Nursing.<sup>1</sup>

### 3.1 Administration and Organization

3.11 Administration of the health services including the general and psychiatric health services should be under one centralized administrator (executive director).

3.12 The organization of the health services should be consistent from one institution to another.

3.13 Nursing policy should be developed in order to establish a unified nursing program throughout the system.

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<sup>1</sup> Report of the Committee on Nurse Practitioners, 1972, Recommendations, Page 22 and 23.

3.14 A nursing consultant should be appointed to the chief health administrator.

3.15 The nursing consultant should become a member of a multi-disciplinary health care delivery advisory group to the chief administrator.

3.16 Medical and nursing consultation should be sought and utilized when new facilities are planned which have a health care component.

3.17 Personnel management should utilize nursing consultation in developing individual position specifications for nurses at all levels.

3.18 Nurses should be responsible to a centralized nursing director for their clinical performance and for following health care policy. Therefore, it is recommended that a director of nursing be appointed to the central medical services.

3.19 Nurses should be responsible to the superintendent for following administrative policy in an institution.

### 3.2 Medical Supervision

3.21 Each nurse or nursing service should have available a physician on a regularly scheduled basis to assure nurses of regular medical and clinical consultation and/or supervision in order to establish and assure appropriate health care to residents.

### 3.3 Education, Supervision, and Consultation for Nurses

3.31 Nursing staff should be encouraged and when appropriate financially assisted to participate in learning opportunities when

they are aimed at increasing their professional competency.<sup>1</sup>

3.32 Each nurse or nursing service should have available a nursing supervisor or consultant on a regularly scheduled basis to assure regular nursing supervision and/or consultation for establishing and assuring appropriate nursing care to residents.

3.33 Since most nurses in the Ministry and particularly those employed in psychiatric and forensic medical units or clinics require substantial updating of psychiatric nursing skills (interviewing, counselling, and skill development in other psychiatric treatment modalities), they should be assisted to utilize training programs developed for learning psychiatric nursing skills.

3.34 Psychiatric nursing consultation and/or supervision should be available to nurses employed in medium and maximum security institutions and in other institutions where prepared psychiatric nurses are not likely to be employed.

3.35 Nurses working with wards of training schools require updating of knowledge about growth and development, including developmental psychology and behaviour. They should be provided with opportunity to attend training programs in pediatrics and growth and development including psychology.

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<sup>1</sup> See Appendix C, Page 41.

### 3.4 Nursing Staffing and "On-Call" Arrangements for Urgent and Emergency Situations

3.41 Current nursing staffing allocation should be reviewed in terms of a) adult inmate's and student's needs and b) appropriate nurse functions in each of the categories of institutions; jails, adult correctional centres, adult training schools, training schools for wards and clinics.

3.42 Arrangements should be made in accordance with the findings of the staffing review referred to in recommendation "3.41" regarding the most appropriate kinds of health service coverage required in each category of institution when professional staff are not available in the building, particularly for urgent or emergency health care situations.

3.43 A system of "on-call" be established in conjunction with the results of the staffing review referred to in recommendation "3.41".

### 3.5 Role, Functions, and Activities of Nurses

3.51 Nurses should not be required to fill in roles of clerk, x-ray technician, dental assistant, housekeeper, porter, escort for inmates and students and such. The appropriate arrangements should be made so that nurses will be encouraged and directed to assume nursing functions.

3.52 The feasibility of employing registered nursing assistants to perform appropriate nursing activities should be considered

in relation to the staffing review referred to in recommendation "3.41".

3.53 Mechanisms for facilitating and assuring continuous communication and patient care planning between nurses attached to the general health care services, the psychiatric services and specialized clinics should be established.

3.54 The addition of prepared psychiatric nurses should be considered for the treatment teams at the A.G. Brown Clinic, the Guelph Neuropsychiatric Unit and other psychiatric clinics and units in the Ministry. This would be in accordance with recommendation "3.55" related to an extended role for nurses. It would also increase the quality of nursing input on the treatment teams.

3.55 Alternate patterns for dealing with admission procedures and sick parade requests be tried in order to determine if there are more effective or efficient ways of managing these aspects of care in the various institutions. Such an alteration might include an extended role for the nurse beyond her present contribution.<sup>1</sup>

### 3.6 Health Care Facilities, Patterns of Care

3.61 Health care facilities should be designed so as to incorporate features which can accommodate the particular needs of:

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<sup>1</sup> For a statement of possible content areas in an extended role for nurses in the health services, see Appendix C, Page 41.



3.611 ambulatory care and infirmary care.

3.612 security requirements of the institutions.

3.613 safety for nursing staff while engaging in nurse-patient relationships that necessitate confidentiality.

3.614 need for individual privacy of the inmate and student.

3.62 Multidisciplinary groups of professionals should be involved in the planning for new health care facilities or in the redesigning of existing facilities.

It is recognized that no list of recommendations devised could cover all possible needs nor hope to rectify completely what essentially has evolved over a long period of time. However, it is hoped that by stating some of the more essential concerns and making recommendations related to the most urgent of these that the changes which are needed to help make the health care, and specifically the nursing services within the system, viable and relevant will be acted upon.

APPENDIX A

Table 1: Institutions Visited, Estimated Number of "Nurses"<sup>1</sup>  
Employed, Number of Nurses Observed or Interviewed  
by Nurse Consultant, March to July, 1972.<sup>2</sup>

Institution visited	Census <sup>3</sup> March 31, 1971	Estimated no. of nurses employed <sup>4</sup>	Number of nurses observed/consulted
<u>SCHOOLS</u>			
Grandview	122	6	5
Pine Ridge	171	3	2
St. John's	188	6	6
Cecil Facer	105	3	1
<u>ADULT CENTRES</u>			
Brampton A.T.C.	133	1	1
Burwash	544	3	2
Guelph	743	9	5
Millbrook	195	1	1
Mimico	362	3	1
Vanier	89	7	3
<u>JAILS</u>			
Hamilton	118	1	-
Toronto	711	11	4
Quinte	99	1	1
Stratford	11	-	-
Cobourg	19	-	-
Brampton	38	-	-
<u>CLINICS<sup>5</sup></u>			
A.G. Brown	-	6	-
Guelph Neuropsychiatric	-	1	1
TOTAL	3,648	56	33

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<sup>1</sup> "Nurses" includes all persons employed for payment, part-time or full-time, except correctional staff, who provide professional and non-professional nursing service.

<sup>2</sup> Source: Nominal Role Medical Services Branch, Ministry of Correctional Services, March 1972.

<sup>3</sup> Figures taken from the report of the Minister 1971:

Schools - Number on school roll and in reception and diagnostic centre, where school has one, March 31, 1971; Cecil Facer not yet open March 31, 1971, approximation given for July 5, 1972.

Adult Correctional Centres - remaining in custody March 31, 1971; including A.G. Brown and Neuropsychiatric Clinics attached to Mimico and Guelph respectively; and Forestry Camps attached to Burwash, Guelph, and Mimico.

Jails - average daily jail population in the period April 1, 1970, through March 31, 1971, Quinte not yet opened March 31, 1971, approximation given for June 6, 1972.

<sup>4</sup> Employed full-time and part-time.

<sup>5</sup> Clinic populations census for A.G. Brown and Guelph Neuropsychiatric Clinics contained in figures for Mimico and Guelph Correctional Centres respectively.

<sup>6</sup> Nurses at Mimico provide general nursing service to A.G. Brown Clinic population.

APPENDIX B

Composite List of Activities of Nurses in the Ministry

1. Assisting the physician with admission, and subsequent physical examination of inmates/students.
2. Inspection of skin: health-hygienic purposes; inspection for body and hair infestation, security purposes; tatoos, bruises, marks, scars.
3. Vaginal examination: adult female if contraband was suspected and the nurse was specifically requested to do so. Assisting the physician when he performed vaginal examinations, positioning, draping, etc.
4. Venipuncture: blood obtained for V.D.R.L., biochemical analysis, etc.
5. Blood pressure, pulse, respirations, temperature, height, weight.
6. Urinalysis dipstick method; glucose, acetone, blood, etc.
7. X-rays, large and small; of chest for tuberculosis screening, also heaf and mantoux testing for the same purpose.
8. Vision screening using: 'Snellen Eye Chart'. Little if any hearing screening, if so a gross screening device such as whispering or watch were used.
9. Health/illness past history, immediate history of complaints, a nominal functional inquiry related to a particular body system if complaint elicited.
10. Counselling and supportive service related most usually to the stress of being newly admitted to the institution particularly children and first offenders.
11. Interpretation of the health services and the role of the nurse in the institution.
12. Obtaining a signed consent for release of health and medical data from previous health services or family, and writing or phoning for the data.

13. Recording activities performed on residents and findings about residents, on the Medical Status Summary Sheet (forms 9801-02).
14. Entering admission physical examination and other visits to health service in the daily log of patients seen in the health services.
15. Instituting therapy and follow-up upon the physician's order (medications, injections, dressings, referral for consultation or services, etc.)
16. Scheduling appointments for further diagnostic and treatment services in the community or in the institution (consultation, surgery, etc.)
17. Supervising and directing others such as inmate-orderlies (e.g. assigned to the ward kitchen, to cook for patients in the infirmary; assist inmates on sick parade to see the health professionals, assist in the hospital and clean health services).
18. Supervising, directing and carrying out nursing care of inmates in the hospital or infirmary. This would include treatments, medications and personal care services.
19. Periodic observation of inmates/students in seclusion, detention and protective custody.
20. Preparing equipment, furniture and records for sick parade.
21. Preparing students and inmates for physical examination.
22. Preparing and distributing medications for "pill parade" and preparing medications for correctional staff to distribute.
23. Making decisions on the basis of observation or by phone about the disposition of inmates with major complaints at times when the physician is not immediately available.
24. Participating in the cottage team evaluation of female inmates and wards as a representative of the general health services.
25. Counselling inmates and students as a part of their psychiatric and rehabilitation program either in a group setting or individually.
26. Assisting the dentist as a dental technician or chair assistant (therefore, preparing equipment, arranging appointments, calling inmates, cleaning up, etc.).
27. Completing initial and reinforcing series of immunizations and giving doses to adults and children.
28. Group teaching - prenatal, personal grooming and hygiene.



29. Ordering supplies and stocking the clinic and infirmary with supplies and equipment including pharmaceutical supplies.
30. Assisting the physician with diagnostic and treatment procedures.
31. Carrying out ambulatory treatments of persons attending or following sick parade (splints, dressings, bandaging, compresses, removing sutures, etc.).

## APPENDIX C

### I. Education of Existing Staff

Nurses currently practicing in the Ministry, and who are interested in and show potential for improving their practice could be offered supplemental, continuing inservice-education opportunities, using community facilities. There is a considerable group of older, married nurses in the system who would not be likely candidates for innovative nursing roles. It would probably be in their best interests to offer on-the-job, informal, service-oriented educational experiences or more formal programs using local Nursing Schools and Colleges of Applied Arts and Technology. Even then it may be difficult to assist some in this group to participate because of geographic isolation and because of the threats inherent in fulfilling a student role.

### II. Extended Role for Nurses

A new role could be envisioned for nurses in the system. The most likely candidates would be graduates from the two-year Regional Schools of Nursing and B.Sc.N. programs who more recently have been utilizing newer knowledge and techniques. The extended role could include physical assessment, treatment and patient management skills, history taking and independent decisions about care at a level beyond that which nurses are currently practicing in the system. Education for the role

should take place in Health Science Centres because of the multidisciplinary content required of such a curriculum and because the appropriate resources for that type of education program are to be found in Health Science Centres.

In order for certain practices to become the responsibility of nurses, a joint<sup>1</sup> committee would need to specify what that practice is, and the education and training necessary to meet it. They would need to gain the official sanction of the Colleges<sup>2</sup> involved so that nurses would be legally covered to extend their practice.

Some practice areas to be considered are:

- diagnostic categories to be treated;
- physical assessment skills and use of equipment including screening procedures;
- management and treatment techniques and principles underlying these;
- history taking;
- emergency care.

The above merely identifies possible areas of practice, more definitive educational programming should await the implementation of the necessary supportive changes within the Ministry's health program and the appointment of appropriate health professionals or other such mechanisms to develop specific curriculum guidelines.

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<sup>1</sup> Committee including nurse and physician educators from Health Science Centres where appropriate resources are available and representatives from the Health Service of the Ministry.

<sup>2</sup> College of Nurses of Ontario; College of Family Physicians of Ontario or College of Physicians and Surgeons of Ontario.

ENQUIRY INTO THE HEALTH CARE SYSTEM  
IN THE  
MINISTRY OF CORRECTIONAL SERVICES

MENTAL HEALTH FACILITIES AND ORGANIZATION

AUGUST 1972

F.C.R. CHALKE

Based on visits to a representative variety of correctional institutions in the province, discussions with administrators, and some of the professionals, and review of published official documents and statistical information, the following information, observations and suggestions are made in connection with mental health services. (Discussion with the Administrative Staff of the Ministry itself indicates an informed interest in the further development of mental health services. With reorganization and new senior appointments there has been little opportunity to enunciate clear or detailed policies on this subject, as yet.)

A. The Purposes and Scope of the Ministry's  
Mental Health Services

Psychiatric services in correctional settings generally have responsibilities, duties, and objectives assigned, which go beyond the "traditional" specialty consultative tasks for the primary, medical services alone.

These goals have included in different correctional settings: -

- 1) Provision of services for the diagnosis of psychiatric illness;
- 2) The arranging for psychiatric care and treatment for the acutely or severely ill;
- 3) The provision of psychiatric care and treatment for the acutely and severely ill, as the resources permit;



- 4) The assessment and supervision of correctional programs for those who suffer psychiatric disabilities;
- 5) The provision of therapeutic psychiatric services (drugs, behaviour therapies, psycho-therapy) on an ambulatory basis for those suffering from illnesses of mild to moderate severity;
- 6) The provision of psychiatric reports and recommendations when required for classification, program assignments, temporary absences, releases on parole, etc.;
- 7) The provision of psychiatric treatment for those not manifestly clinically ill, but where the offence or offences clearly arise from underlying psychopathology, e.g. masked depression, latent schizophrenia, some personality disorders;
- 8) The provision of medico-psychological therapy on a trial basis for those whose offences appear to arise from, or be related to behaviour disorders, e.g. fire setting, incest, drug addiction;
- 9) The provision of psychiatric after-care, follow-up and continuing medical treatment for those on parole and those under the care of voluntary after-care societies;
- 10) Acting as advisors to the administrators of institutions regarding mental health aspects of practices, procedures and programs with a view to reducing psychiatric illnesses

of a preventable nature by ameliorating tensions arising from isolation, physical threat, dependency status, etc.;

- 11) The provision of psychiatric counsel to staff in regard to emotional problems involved in staff-inmate relations, working conditions, and changing programs. Psychiatric consultations may be particularly useful in resolving difficulties which inevitably arise in new approaches as in Living Units;
- 12) The provision of consultations and reports, regarding pre-release and parole, to the parole staff and to personnel of after-care agencies concerning mental health needs and problems to be faced by inmates with psychiatric disabilities after their parole or release;
- 13) The provision of on-the-job staff training for custodial and correctional staff with respect to matters within the competence of the psychiatric service professionals, e.g. detecting suicidal risks, management of impulsive or violent behaviour, recognition of symptoms of an approaching crisis;
- 14) The provision of appropriate training programs for Universities and other educational institutions in the field of psychiatry as applied in the correctional field, for psychiatric residents, nurses, clinical psychologists, therapists;
- 15) Engaging in research in relevant fields of psychiatric criminology, penology of abnormal offenders, research methodology, etc.

Even when resources of professional personnel are unlimited, it is desirable to establish some priority amongst such possible roles. It is essential of course, when the resources are in short supply, that this be done.

There does not appear to be any overall direction from the Ministry in this matter, and each superintendent appears to direct his psychiatric staff, in accordance with his assessment of the priorities and undoubtedly with the aims, interests and special skills of each professional, influencing such duties.

While the selection of "priorities" may be better established at the local level depending on -

- a) availability of professional personnel;
- b) the differing duration of sentences;
- c) types of inmates;
- d) age and sex of students, etc.,

it would appear necessary to establish what the Ministry, as a whole, expects of its psychiatric services in order that numbers, qualifications and amounts of time required, by each institution, can be broadly determined and budgetted.

#### B. Observations Based on Visits and Discussions

The only word that can describe the psychiatric component of the Medical Services of Ontario Correctional Institutions is "variability".

- 1) There are two full-time psychiatrists in the service, a number of committed major part-time psychiatrists and several serving on a retaining or "fee for service" basis.
- 2) The professional psychiatric staff that I met appeared qualified and competent. Several manifested outstanding devotion to their responsibilities. Others that I did not have a chance to meet, on these visits, are known to me and are equally qualified although some of them may not have sufficient continuing contact at an intensity to develop equivalent interest and special skills in relation to their work in the Correctional Service.
- 3) The working accommodation for psychiatric staff and for patients varied from adequate to seriously deficient. In the latter instances this was associated with overall space limitations in the institution well known to all concerned.
- 4) Each institution makes its own arrangements in providing psychiatric services for inmates or students on a pragmatic basis depending on size, location, interest and availability.
- 5) Another important variable is introduced by the degree of awareness and attitude of the general physicians in different settings to psychological differences, needs and abnormalities of their patients.

- 6) There appears to be ignorance or disregard both by administration and medical staff in some setting of the roles, responsibilities and competencies of various members of the "psychological" professions - i.e. psychometrists, psychologists, psychiatrists and psychiatric social workers. Whereas the general medical service may be careful to regulate carefully the authority of the physician, nurse, hospital officer, etc., there seems much less clear discrimination by them, amongst the "psychological" specialists. Similar problems in diagnosis and therapy seemed to be assigned to whichever person is at hand, whether or not registered psychologists or psychiatrists are available to take individual case responsibility.
- 7) The professional relations between members of psychological professional staff seems also to vary. In some settings the psychiatrist clearly sees himself as a consultant on all individual cases to the medical service and sees cases on referral and reports fully to that service. In others there appears to be two separate services with self or staff referral arising separately to each but with at least a verbal assurance of "close working liaison" between the general medical and psychiatric services.



In some settings the psychiatrist applies the medical model in his relationship to other staff, whether he operates through the medical department or not, and assumes the responsibility as a physician for those under his care. In other cases he generally assumes a position on a team undertaking modification of social deviancy without himself, or anyone else, assuming a position of professional responsibility.

- 8) Lack of clear policy of the Department of Health Hospitals as to criteria for admission and responsibility for custody for those referred by Prison Medical Services was apparent. There appears to be a tendency to utilize use of involuntary admission forms whether or not the prisoner is willing and able to seek treatment, possibly as a device to maintain custody which attempt the purpose usually achieved by "hospital orders" in other countries. This method frequently fails since even those mental hospitals, provincial or otherwise with closed "forensic" units reserve these for court referrals and admit sick offenders under the care of the Ministry of Corrections to open "domestic" wards.

There are at all times some, albeit a variable number, of inmates who fall within the mandate of both the Ministry of Corrections and the Ministry of Health. Dependent solely

upon local arrangements, local goodwill, local acquaintance-ship, local cooperation, an individual may or may not be expeditiously and appropriately handled.

No general guidelines, jointly agreed to by the two Ministries are in evidence to resolve conflict at the local level when it occurs between their respective institutions.

It is recommended that some directives be evolved based on inter-ministry policies.

- 9) One of the most inequitable situations across the province is created by the absence of any known or ascertainable policy regarding the provision of psychiatric services to both the Ministries of Justice and Correction Services, by the Department of Health.

In one locality there is support; through funding to community agencies by the Ministry of Health, to provide in-patient and out-patient services to adult courts, to probation services, to correctional medical services and after-care services (Clarke Institute out-patients services). Similarly, Department of Health Funds provide to some Family and Juvenile Courts, extensive clinical pre-sentence and treatment services for juveniles. These initial examinations provide, when available, valuable contributions to the training schools when children are admitted. In the absence of stated policies, the basis of funding, e.g. per capita? case load? number of regional courts? is not

available and hence appropriate community agencies cannot rationally plan such services with the local courts and correctional institutions.

It is suggested that the Ministry of Health be requested to enunciate its regulations on this matter so that regional correctional services can plan meaningfully with regional mental health centres to develop on a regional basis equitable services.

- 10) The questions of "right to treatment" and "right to refuse treatment" need clarification MS: 07:06 stating that consent for essential treatment of a certified patient can be given by the superintendent if refused, is based on the Deputy Minister's opinion in 1952. The new Mental Health Act of Ontario 1967 does not refer to certification and it was not the intent of that act to permit the superintendent of the restraining hospital to act 'in loco parentis'. If this is the power of prison superintendents then it surely is "in general", and has nothing to do with "certification" whatever that is.

Similarly, MS:07:11 states that medication can be administered without the inmates' consent if he is "the subject of an application for admission to a psychiatric facility". This certainly is not the law in Ontario and implies the loss of some right that

the inmate possesses when NO such application is made.

- 11) Amongst the institutions visited there were three adult correctional centres - Millbrook, Burwash and Rideau - with almost total lack of psychiatric consultative services.
- 12) Gaols present a wide range of adequacy of services. Because of the role of jails with a high turnover of people 'off the street', the problems are often immediate and often medically serious. In small jails this is usually managed on an ad hoc basis and because the situations are relatively infrequent can be managed only in this way.

In the newly evolving regional detention centres however a more structured arrangement appears advisable, because of the numbers involved and might take the form of sessional appointments based on a half day per week for each forty inmate capacity of the regional detention centre. This psychiatrist could be assigned tasks 1, 2, 3, 10, 11, 13, from those listed in Section A (above). Additional requirements would have to be made to cover services to courts. The pattern too would be modified if facilities for the care and custody of the ill prisoners were provided in related mental health institutions with appropriate financial arrangements between Ministries.

- 13) One major problem is the utilization of the Ministry of Correction Services psychiatrists, to provide psychiatric services to adult courts in spite of the Medical Services Manual regulation MS:07:01 to the contrary.

The problem created makes it difficult to obtain the services of psychiatrists interested primarily in clinical care of ill prisoners or for assessing clinical problems for the medical service.

- 14) In settings with limited psychiatric services there is a tendency for those with personality disorders, and latent or subclinical disorders to be assigned in special areas for custody often referred to as "medical" units.

The inmates in these areas are sometimes assigned there by the Medical Officer, sometimes with his knowledge and sometimes with neither his permission or knowledge. In some cases the psychiatrist in attendance utilizes such a location for extended observation or care. On the other hand there is a feeling amongst most professional staff and senior administration that they do not wish to identify any area within the institution as specifically for those with minor or moderate psychological abnormalities. This is particularly true in training schools. There needs to be flexibility and discussions at all levels of attitudes, feelings and evolving of the optimal if not ideal solutions for this problem.



C. Specialized Mental Health Units within the Ministry

There are two adult male psychiatric units or clinics identifiable as such within the correctional services. (This in no way indicates that diagnostic and treatment facilities are lacking for juveniles or females, in fact a clinical treatment approach may be said to overlay the whole correctional program in these latter institutions.)

The Neuro-Psychiatric Clinic at Guelph and the various components of the A.G. Brown Clinic associated with Mimico Correction Centre require special comment -

- 1) The evaluation of the major portions of the A.G. Brown Clinic's programs has been dealt with in the comments concerning addiction and drug abuse. (See Appendix D.)

Psychiatrists and other Mental Health Professionals are actively involved in this program, and it appears to represent a specific therapeutic program for selected individuals with certain assets and motivations, and could be seen as one specialized program within the overall clinical (mental health) programs of the Ministry.

- 2) The other unit is the N.P.C. at Guelph which has rather quickly changed its role over the past two years from a holding unit for a relatively small number of inmates to a more active diagnostic, triage and short-term acute in-patient treatment unit coping with about 4 times the number annually admitted (and discharged) than previously.

- 3) Patients discharged, in the largest number return to or are transferred to G.C.C. From there they continue in some cases to return for ambulatory care at the clinic for the balance of their sentence. Other patients transferred to Millbrook, Burwash, etc., do not have the same opportunity for continuing ambulatory psychiatric care as such.

The possibility of establishing a special residential continuing treatment unit within G.C.C. to which suitable inmate patients diagnosed at the N.P.C. could be assigned for all or part of their sentence, has been raised. Problems are foreseen in having a visible group of psychiatric patient inmates within the general population of G.C.C. with the many difficulties that this can raise for administration, for antagonisms, secondary gains, hazing amongst inmates, maintenance of clinic officers identity amongst correctional staff, etc.

- 4) At least two possible alternatives exist for the Ministry in dealing more effectively with the manifestly psychiatrically ill or presenting complicated diagnostic problems.

A. By the maximum utilization of the publicly established health care resources, offered by the province in its provision of comprehensive health services to all citizens

OR

B. To attempt to develop adequate, second order specialty care facilities, separate from these, under the sole jurisdiction of the Ministry of Correctional Services.

- 5) The first choice offers a better system in terms of maintenance, quality of care, clarity of objective, simplicity of operation at the institutional level, regionalization, continuity of program and possibly economy of scale.

Its main drawback is the demand for a degree of inter-ministry agreement of operational principles in all spheres, including financial, custodial and priorities, and institutional relationships, which up to this time has not been generally evident.

(The one exception has been the care of inmates requiring maximum security at Oak Ridge Division of the Ontario Hospital Penetanguishene, which offers hope that "it can be done".

- 6) With all the drawbacks of distance of travel, conflicts of goals, difficulties in maintenance of professional staff, lack of the full range of professional skills, the second choice would have to be to re-allocate the N.P.C. to the new clinical facility at Brampton in association with the present staff of the A.G. Brown Clinic. This would provide a number of options -

- a) There could be one administration with a number of treatment services including those for conditions now treated at the A.G. Brown Clinic.

- b) There could be a unified medical/psychological assessment and diagnostic service that could evaluate suitability for a variety of treatment programs including those for addiction, sexual disorder, arson, psychopathy, etc.
- c) Inmates not requiring continuing special residential treatment programs could be returned to the neighboring adult training or correctional centres (Mimico, Guelph, Brampton, etc.) and professionals from the expanded N.P.C. attend these centres regularly to see ambulatory patients, consult with general medical officers, classification, staff and administration.
- d) If special one of a kind diagnostic facilities were available at the N.P.C. then women prisoners from Vanier Centre could easily be transported there for examination.
- e) This would reduce the stigma and administrative problems of trying to run small special psychiatric residential treatment units within a general prison.
- f) It would allow more flexibility in introduction of various treatment programs for those with varying degrees of motivation, intellectual assets, etc., rather than the present situation where those unable to meet the criteria for the present A.G. Brown programs are left without readily available alternatives.

- 7) Wherever the N.P.C. is located it would be of advantage to have it declared a psychiatric facility under the regulations of the Mental Health Act of Ontario 1967 in order that patients can be treated there with as near as possible the same standards, protections and opportunities that apply to other psychiatric treatment facilities.

D. Staffing and Operation of Mental Health Services

- 1) Just as with the provision of general medical services, it would be of advantage if contracts could be concluded by each institution with organized groups of psychiatric professionals either based on a hospital or as a partnership, which would ensure better total coverage when illness, vacations, study leaves, etc., require absence of one professional or team. When possible, this contract would be most appropriate with a group associated with one of the educational health sciences complexes in Ontario to ensure development of increasing numbers of professionals trained in correctional psychiatric services.
- 2) Both from the point of view of "cost/benefit" evaluation and as a contribution to basic knowledge it is important to establish means to pursue high quality operational research in the field of correctional psychiatry in the Ontario program. This could be assisted by -



- a) The establishment of relationships to appropriate Ontario Universities referred to above.
  - b) The provision of adequate data bases, follow-up mechanisms, standardized measurements and descriptions, by the Ministries research branch.
  - c) By providing advisory consultants to assist in the design, procedures and assessment of on-going research.
  - d) By encouraging, or at least permitting, publication of competent research findings.
  - e) By utilizing the research engendered information to modify, develop or discontinue appropriate programs.
- 3) The continuing education and relevant development of special skill and knowledge in dealing with offenders, requires that all Ministry of Corrections mental health professionals have an opportunity to attend regularly seminars, workshops and/or conferences dealing with their special areas of concern in addition to ordinary professional conventions of psychiatrists, psychologists, or psychiatric nurses, etc.
- 4) While uncertainty was expressed as to the role and value to the practitioners of a full-time Director of Psychiatric Services at the Ministry there was support for consultants or an Advisory Group who would be able to visit institutions with

psychiatric services to provide advice, coordination, and professional consultation.

- 5) There are already two or three informal groups of psychiatrists interested in forensic and/or correctional psychiatry meeting at irregular intervals in Ontario and there are suggestions that the Ontario Psychiatric Association might be requested to form a Section devoted to this interest. The Ministry might consider some contribution to such a section, if formed, to the extent of encouraging its staff to belong and attend meetings, accept office, support occasionally visiting speakers, etc.

#### E. Irreconcilable Areas of Uncertainty in 1972

The findings of this survey of psychiatric services in this jurisdiction make manifest the three "areas" of wide spread concerns in correctional services throughout the Western World. Each of these generates conflicts, which are not resolvable at this time, by any one institution or even by a single ministry since they reflect inherent differences in social policy during a period of evolution and change.

- 1) The first of these is the continuing paradox of trying to organize and administer a treatment program, for the benefit of an individual, in an environment and under a mandate, that has other and sometimes contradictory objectives. Lady

Barbara Wooton after years of confronting this problem has come to the conclusion that it is without resolution in the present social context and climate (Reference C. P. A. J. )

- 2) A second problem is to define the boundaries of the concerns of "health services" - Are they concerned in the maintenance of health of all inmates including mental health? If not there are no rational, agreed criteria to distinguish the "ill" from the "healthy", therefore no system that can clearly allocate all of the inmates to either a "sick" or "well" role.

For the specialty of psychiatry this is not a problem confined to corrections, but is a wide-spread problem in the health services of most civilized countries and therefore cannot be resolved by utilizing any accepted "medical" criteria.

- 3) With a broad, indistinguishable, well populated "grey zone" between the clearly sick, and clearly well, the territorial borders and disciplinary barriers between, particularly clinical psychology and psychiatry, are in constant flux and confrontation. Over the past twenty years the conflict has persisted without resolution of the claims and counter claims as to rights, privileges and responsibilities with regard to matters of diagnosis, prescription and psychological treatments, by the disciplines concerned.

Therefore, in considering the health service of Ontario Corrections one must recognize that these well-nigh universal conflictual areas persist and cannot be resolved by any recommendations of this commission. All that can be done is acknowledge the differences and adopt measures, in the meantime, to render the best, safest, most acceptable services that the circumstances permit.

July 17, 1972

REPORT TO DR. E.H. BOTTERELL ON DENTAL CARE SERVICES  
IN THE MINISTRY OF CORRECTIONAL SERVICES

This report is based on information obtained from interviews with superintendents and dentists associated with the various categories of institutions under the Ministry of Correctional Services. All full-time and a number of part-time dentists were interviewed. Although not all institutions were visited, the majority (except for jails) were. In some instances where no visits were made, telephone interviews and/or correspondence provided information. No direct dental survey or interview of inmates was conducted.

The terms of reference for this report were described by the Minister of Correctional Services, C.J.S. Apps, as:

'to inquire into the Dental Care Services role of the Dentists available and needed to fulfill the "Statement of Purpose" of the Department. This will include examining the needs of the Department in the delivery of health care now and in the forthcoming decade. The utilization of auxiliary personnel as a means of providing an increased volume of dental services with minimal increased cost requires special consideration. Included also should be consideration of provisions for continuing educational programs to ensure a high level of ongoing professional competence of the full time Dental Staff.'

The report is organized so that a summary of its recommendations and an outline of its contents appear first. This is followed by a discussion of the dental health problem and a description of the existing dental health program, its staff and facilities. A section on suggestions for dental health program staff and facilities in the future completes the report.

Respectfully submitted,

(Signed) D.W. LEWIS, D.D.S.  
Dental Consultant



## SUMMARY OF RECOMMENDATIONS \*

### Service and Patient Aspects

- i. Clarification of dental treatment guidelines and development of an effective means of communicating these is necessary (47, 48, 49).
- ii. Existing variations within each institutional category in patient entry to dental care services and treatment available should be removed (50, 53).
- iii. Dental program staff and facilities should be expanded to accommodate anticipated future increased demands and to permit virtually all inmates to have an initial oral examination (51).
- iv. Preventive services should be routinely available to, and promoted for, inmates (52).
- v. Consultation with, and referral of patients to, dental specialists should be available for each institution (54).
- vi. Policy variations in respect to inmate payment for dentures should be standardized in favour of no payment; protection from inmate abuse of the prosthetic service should be by guideline and an effective follow-up record system (55, 56).

### Staff Aspects

- vii. Existing anomalies in dentist supply among institutions within each institutional category should be removed (57).
- viii. Chairside dental assistants should be routinely available to dentists (58, 59).
- ix. Full use of existing and of new types of dental auxiliaries with expanded duties as these become available, should be made (60).
- x. Bursary support by the Ministry for persons undergoing undergraduate auxiliary training to ensure an adequate supply of auxiliaries for the dental program is advisable (61).
- xi. Salary scales of dentists and dental auxiliaries should be competitive with private practice if good people are to be recruited and kept (62).
- xii. A full- or part-time dental educator (preventive dental assistant or dental hygienist) should be employed by the Ministry to develop and carry out a dynamic educational program for small groups in training schools and for selected groups in other institutions (63).
- xiii. Dental staff association with adjacent hospitals, clinics and other institutions should be encouraged (64).
- xiv. An extensive, dynamic continuing education program for dental staff should be established (65).
- xv. A part- or full-time dental program co-ordinator should be employed (66).

### Facilities, Supplies and Equipment

- xvi. The feasibility of expansion of existing institutional dental facilities to two chair units should be studied (67).
- xvii. New facilities should have two dental operatories and professional consultation regarding the efficiency of office arrangement should be sought prior to the development of new facilities (68, 69).
- xviii. Improved arrangements for ordering dental supplies are necessary (70, 71).

\* The figures in brackets at the end of each recommendation are the paragraph numbers in the main report where more detail is given. Also, the appropriate section in the Table of Contents provides some of the necessary background information which lead to these recommendations.

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## THE DENTAL HEALTH PROBLEM

### Assessment of Needs for Dental Care

1. No survey data of inmates' or students' dental disease attack or treatment levels achieved are available. However, it is evident both from the comments of the involved dentists and from limited survey data of similar age groups in Ontario (school children and Army recruits) that at admission dental disease attack (periodontal disease and dental decay) is high and prior treatment levels are low. Thus treatment needs of the institutional residents are high, and probably higher than those of the general public.

### Nature of Adult Inmate Demands for Dental Service

2. While there are exceptions, initial demands for care generally reflect negative attitudes to dental health and care. Demand for care then, although usually more accessible to the inmate within the institution than outside, is markedly disproportionate to what treatment needs suggest it ideally should be. In spite of this discrepancy, treatment demands are sufficiently high to tax the existing dental care delivery structure. No dentists claimed or appeared to be not busy enough.

3. The questionable type of care perceived as desirable by some inmates, e.g. extraction of repairable teeth, was a common observation by dentists. Although these same fatalistic attitudes about teeth are found in the community, they are apparently more frequent in the institutionalized population.

4. Changes in demands for care over time are occurring. The demand, especially for cleaning and scaling of the teeth and improvement of appearance by restoration or replacement of anterior teeth, apparently is increasing. This parallels documented similar changes in attitudes and demands in the community at large but also may be due to the more youthful prison population today, the successful efforts of the dental staff to educate patients and the influence of satisfied inmates who themselves, perhaps inadvertently, slowly convert those initially hostile to dental care. Whatever the reasons inmate demand for dental care will continue to increase in the future.

5. High demands for partial or full dentures are a source of concern in some correctional centres with short term prisoners.

#### The Organization of Correctional Institutions

6. Another factor in addition to needs and demands which bears heavily on the type and extent of current dental care services -- and thus is an integral part of the dental health problem -- is the stratification of institutions into training schools, adult training centres, correctional centres and jails. Present dental program philosophy and organization clearly recognize the rehabilitative potential and detention time aspects underlying this stratification and the numbers involved in each stratum. These strata, and particularly variations in the dental program within stratum will be referred to later in this report.

## THE PRESENT DENTAL PROGRAM - SERVICE AND PATIENT ASPECTS

### Program Guidelines and Philosophy

7. Dental treatment guidelines and priorities are contained in section 4:00 of the Ministry's Medical Services Manual, dated April, 1972. Other directives to dentists have appeared from time to time. Section 4:00 indicates the extent of treatment responsibility of the Ministry according to type of institution. Briefly, for those on remand or short sentences in jail, relief of pain and treatment of acute infection is in order; for adults in correctional centres, criteria of adequate mastication and a good appearance are suggested; for training school pupils, complete rehabilitation is the general rule. Work beyond these criteria is to be done at the inmates' expense, if sufficient dentist time is available. General anaesthesia for dental work is not recommended.

8. These guidelines seem to be followed quite closely in training schools and jails. Although "relief of pain" for those in jail would include fillings to relieve tooth aches where extraction is not necessary, very few teeth are filled. The guidelines for correctional centres permit wide interpretation. The variety of operational criteria actually used from institution to institution reflect not only these flexible criteria but also the nature of the institution itself (short term vs. long term), the availability of dental staff, the dentist's attitude and the superintendent's philosophy.



9. No institution I visited seems to deny reasonable treatment requests for inmates with good rehabilitative potential, if staff treatment time is available. The dental program philosophy generally seems to accept but with judicious application, the Ministry's "Statement of Purpose", number 2.

#### Patient Administration

10. Patient entry into the dental care service is variable. In some institutions (nearly all training schools and most correctional centres) all residents are examined soon after admission and many are dentally radiographed, while in others (jails, some correctional centres, and at least one training school) the onus for entry into the system is on the inmate or student. In this latter situation inmates in some institutions must first go into the medical sick parade for referral to the dentists, in others, there is a specific dental sick parade. In the former situation where all new arrivals are examined, in most but not all institutions basic treatment services are subsequently available to all those who elect them.

11. After entry into the dental service, the efficiency of patient flow was assessed. Most dentists felt there were no problems here although in some instances circumstances dictate that patients be called to the dental office one-by-one with some delays between patients. In multiple-building institutions the dental office may be some distance from the building in which the patient is working or residing. At the other extreme, in one instance, all patients for each half-day's

appointment schedule are brought in at one time, then treated successively without delay or problems -- at least for the dentist.

#### Dental Services Provided

12. For purposes here dental services may be categorized into:

(1) diagnostic services (a thorough oral examination, radiographs, treatment planning, i.e. not to include a short examination);  
(2) preventive services (e.g. scaling and polishing of teeth for adults, or cleaning and topical fluoride application for children, and dental health education) and; (3) treatment services (several levels of this exist, e.g. emergency relief of pain by extraction, or basic operative treatment -- fillings, extractions, periodontal scaling and occasionally endodontics, or prosthetic treatment -- partial and full dentures, or comprehensive specialty treatment -- crown and bridge work, orthodontics, other specialty care).

13. Keeping in mind that in some institutions not everyone is seen by the dentist (paragraph 10), dental services in jails are largely extractions for relief of pain while dentists in the other institutions provide to varying degrees all of the services listed in paragraph 12 with the exception that comprehensive, special treatment is very limited and that except for training schools, preventive services are minimal.

14. Referrals to specialists (orthodontists, oral surgeons, endodontists) are arranged occasionally for highly selected cases. This poses a number of problems, one of which is geographic for institutions far

from large cities. Some dentists are concerned that they are at times forced by the lack of reasonable access to specialists to involve themselves in difficult surgery (e.g. third molar impactions and multiple extractions on difficult patients) which goes beyond the hazy borderline of competence of a general practitioner.

### Dentures

15. Payment for partial and full dentures usually is at public expense.

In some institutions if the inmate has sufficient money in his savings account he is assessed about one-third of the laboratory's costs -- about \$11 for a single complete denture. It is felt that these inmates will appreciate their dentures more and care better for them. In other institutions, even though the inmate has a similar amount of money, this is not done, apparently for a variety of reasons -- the man who has saved money should not be penalized; if the inmate needs this for appearance or health he should not have to pay for it, etc. However, since few inmates have sufficient funds this dilemma arises infrequently. But for those with funds, institutional policy varies.

16. The prosthetic laboratories (where dentures are fabricated) used by the dental service are of two types. Most institutions use private, commercial laboratories in adjacent towns with apparently satisfactory results and at reduced costs for a bulk contract. The laboratory at Guelph Correctional Centre provides acrylic partial and full dentures mainly to Guelph and Burwash. Curiously, the cost per denture from

the Guelph laboratory is practically equal to that of the commercial laboratories so that no appreciable saving to the Ministry is evidently possible by increasing the number of its own laboratories. It should be stressed that dentists in Burwash and Guelph are well-satisfied with the convenience and quality of the laboratory work provided in the Guelph Correctional Centre.

17. Short-term inmates and frequent repeaters in correctional centres who require dentures pose particular problems for administrators who, at times and with perhaps some justification, question the provision of dentures at public expense for these people, particularly when rehabilitation is not a major issue.

#### Records

18. All institutions keep individual patient records, usually dental chart 9E but in several instances other charts are used, because of dissatisfaction with the standard chart. Upon release or transfer of a resident, his chart is usually sent to the main administration office presumably for central filing or forwarding to another institution. Some of those interviewed questioned the efficiency of the current system since previous patient records for repeaters were subsequently not always obtainable.

19. Some dental departments compile daily, then monthly summaries of work done. Monthly reports are to be sent to the Ministry and these would be valuable for a detailed study of dental care services. For

dentists on fee-for-service the itemized statements submitted for payment act, in effect, as monthly reports.

20. Some of the forms used are out-dated but the revisions needed are minor.

21. The filling-out of forms while not an impossible task is a nuisance for the dentist when no regular dental assistant is available. Significantly, this task seems to be most effectively carried out in those few institutions with regular dental assistants.

#### Program Adequacy -- Services and Patient Aspects

22. No totally acceptable definition of program adequacy in regard to services is available. Adequacy is a highly subjective matter but might be approached from four points of view: (i) the extent to which demand for care is satisfied; (ii) the extent to which dental needs are met; (iii) continuity of care and; (iv) fulfillment of the Ministry's Statement of Purpose. Since no interviews with inmates or surveys were conducted, adequacy from the point of view of the consumer-inmate can only be inferred from these other considerations.

23. Demand for care largely is satisfactorily met, although in some institutions increasing patient demands are causing problems. Also, it should be emphasized that in some institutions demand is not encouraged, for example all patients are not examined. Indeed the view was expressed that to do so would create demands that could not be satisfied with the existing staff and time available.



24. The extent to which dental need for treatment is met varies, both among institutional strata and within each stratum. In most training schools, and in some correctional and adult training centres, a high percentage of residents (85%-95%) apparently have received good basic dental care and are reasonably dentally fit upon discharge. In the remainder of these types of institutions, the program is less than adequate in respect to meeting treatment needs. Likewise in jails no attempt to meet total dental needs is made, even for those in jails for surprisingly long periods of 3 to 6 months.

25. Continuity or regular availability of care, say for the relief of pain, largely depends on the frequency of the dentists' visits. This is not a major problem except in large jails where the dentist spends one specific half-day per week. Even so, if prescribed medication does not relieve the pain, special arrangements for appointments may be made. No coverage for dentists on holiday is apparently arranged but special emergencies could usually be handled locally.

26. The dental program generally is adequate in relation to the appropriate section of Statement of Purpose of the Ministry, although as described above, the application of the Statement in a broad sense is not universal.

27. Certainly the dental program as a whole now bears little resemblance to the limited emergency extraction service of former days.

## THE PRESENT DENTAL PROGRAM - STAFF AND FACILITIES ASPECTS

28. Although the circumstances under which they work are sometimes difficult and frustrating, I was generally pleased and impressed by the integrity of, and concern for patients displayed by, the dentists I visited.

Their work is a sort of sub-specialty for which there is no formal preparation available. They are not in my view, second-class citizens of the dental profession and every effort should be made to help them provide and improve their service and to remove the sense of isolation and professional alienation that some of them feel.

### Staff -- Dentists

29. The Ministry employs a number of dentists under a wide variety of payment basis: full-time; part-time; sessional; fee-for-service. Four of the six full-time dentists work in more than one institution.

30. Although inadequate in many respects, the standard measure of dental manpower supply in the community is the dentist:population ratio. Say several training schools with an average daily population of 250 have one full-time dentist assigned -- a ratio of 50 students/dentist/day/week might be derived. A crude estimation of actual ratios for the Ministry's dental services indicates that in training schools a low of about 50 students (the example cited) to a high of 100 students/dentist/day/week. For correctional centres the range is from 80 to 120 inmates per dentist/day/week. Ratios for these institutions are particularly difficult to interpret meaningfully because although average daily

population is used, the effective population entering an institution annually is much higher than this average. Also, the patients have high treatment needs and extra time is required for explanation and education because of their infrequent previous exposure to clinical dentistry. Accepted ratios outside institutions don't apply.

31. In spite of these problems in interpretation, the ratios show wide variations which indicate, at least in qualitative terms, differences in the amount of dentistry which can be delivered. Other apparent anomalies in dentist supply within each institutional category are found. For example, in two of the more prominent jails, the time assigned to the dentist in each institution is identical (one-half day per week); however, one institution has 6 to 10 times more inmates than the other.

#### Staff -- Dental Auxiliaries

32. First a few comments about dental auxiliaries -- a variety of dental auxiliaries exists today, including chairside dental assistants, preventive dental assistants, dental hygienists, dental therapists, dental technicians, etc. The chairside assistant-secretary is the standard auxiliary for most dentists and studies have shown that the addition of this auxiliary significantly increases productivity. Currently experimental work is underway in Ontario to test the feasibility of expanding the duties of both dental assistants and dental hygienists. Also, training of dental technologists who will provide dentures directly to

the public is scheduled to begin shortly.

33. There is a paucity of trained dental auxiliaries working in the dental program of the Ministry -- one dental assistant full-time and one part-time, two days per week. Interestingly, these two were employed initially many years ago because the two dentists who started the two dental programs insisted on it.

34. Several of the dentists who work on a fee-for-service basis use their regular assistants when working for the Ministry. Others use inmates who have received on-the-job training. Although on occasion this has worked out well, little real chairside assistance is provided by the inmate and, of course, short sentences argue against this as a satisfactory answer for a continuous full-time service.

35. The use of nurses as assistants is unsatisfactory both from the nursing and dental points of view.

#### Staff -- Remuneration

36. Fee-for-service is the payment mechanism in jails and in a limited number of correctional centres and training schools. The fee schedule used is that of the Workman's Compensation Board although this apparently is not always so. Salaries of dentists are low; the high of the recently increased range is about \$2,000 below the average general practitioner's net income from practice. According to figures given me, the salary of dental assistants -- hardly a major item in the present system -- appears to be reasonable since no formal academic

training is essential. The salary of the one laboratory technician is embarrassing low -- a victim of the evils of government job classification.

#### Staff -- Specialists

37. The Ministry employs no dental specialists as consultants although some cases are referred for special treatment. Lack of specialists apparently creates some problems (see paragraph 14).

#### Staff -- Opportunities for Continuing Education

38. Opportunities for continuing dental education are minimal -- attendance at the Ontario Dental Association convention is supported every two years. Some special requests have been granted to attend other meetings. No specific short courses, workshops, demonstrations or lectures on subjects particularly relevant to the activities of the dentists or on newer techniques have been arranged. All dentists I interviewed are cognizant of the need for additional training and one man has taken some appropriate short courses on his own time at his own expense.

#### Facilities -- Equipment, Instruments and Supplies

39. Most large and small equipment is fairly modern and in good repair. Most operatories have x-ray units. All dental units have high speed air-rotor drills. Some of the newly-acquired units and chairs are not of the latest design which may require adjustments of practice style for new recruits a decade or less from now.



40. The time between ordering of small instruments and supplies is very slow and a source of concern. Some part-time men bring supplies from their offices to get around delays. However, in one institution an annual budget is set for supplies which are ordered directly by the dental staff who also inform the administration for the record and there are no delays.

41. Detail men from dental supply houses do not visit the dentists.

#### Facilities -- Office Space and Arrangement

42. Most, not all, dentists are reasonably satisfied with their offices in relation to the existing program.

43. The single main dental operatory room is usually spacious and bright although in one new institution it is amazingly small, cramped and of a bizarre shape. In just one institution is there a second operatory which is partially equipped. One or two dentists claimed a second operatory would be utilized effectively.

44. Other office space includes in a couple of cases a separate dental waiting room and often a small adjoining laboratory for developing radiographs and grinding dentures. In only two of the places I visited were the office arrangements close to ideal and one of these arose fortuitously since the original plan for part of this space did not materialize.

45. Usually the dental office is located adjacent to the infirmary but there are cases where it is located in a completely separate building.

46. The efficiency of design arrangements -- placement and style of cupboards, shelves and equipment -- is not of the most modern concepts, even in newly developed facilities.

## SOME CONCLUSIONS - A DENTAL PROGRAM FOR THE FUTURE

This section consists of a series of conclusions (or recommendations) which if implemented will improve the dental program.

Obviously, any changes would come in phases and need extensive co-ordination. I have suggested a dental co-ordinator would be required to help the present administration in this.

### Service and Patient Aspects

47. Clarification of dental treatment guidelines particularly for jails and correctional centres is needed. This is a difficult task as a certain amount of individuality in respect to patient treatment and for each institution is desirable. But the basic guidelines which would apply for the majority of residents are not at present well understood. A more specific sentence-time element in the guidelines for dentures would be helpful.

48. An effective means of communicating these new guidelines to the administration, medical and dental staff would need to be developed.

49. The present idea of stratification of maximal treatment criteria according to type of institution should be retained in any new guidelines but these should be stressed as minimal criteria which in selected cases can be extended but at no additional cost to the inmate.

50. Existing variations within each insitutional category both in entry to the dental program and in the treatment then available should be

removed.

51. The dental program should be expanded in terms of staff and facilities to accommodate future increased demands for care and so that virtually all inmates (except those on very short sentences in jails as defined by guideline) receive soon after admission a thorough oral examination and an explanation of their treatment needs and personal responsibilities for maintenance of oral health. The minimum treatment available to them according to the guidelines would also be reviewed.

52. Selected preventive services should routinely be available for adults in correctional centres and particularly for adult training centres. Prevention should be stressed heavily by dentists in dealing with all patients. Issues of tooth brushes and an acceptable dentifrice to all residents should be standardized.

53. Restoration rather than extraction of bothersome teeth when indicated, should be emphasized in the jail program and the means whereby this can be accomplished, arranged.

54. Definite arrangements for consultation with and referral to, dental specialists should be established by organizing a regional panel of appropriate specialty consultants for each institution. This would include the use of general anaesthesia when definitely indicated. In some instances, arrangements for follow-up care after release, e.g. orthodontics, would need to be negotiated between the appropriate

consultant and the administration.

55. The variation in policy regarding inmate payment for dentures should be eliminated in favour of a policy of no payment at inmate expense. Protection from abuse, e.g. numerous dentures of public expense, should come from guidelines and from an effective record system which would identify at a glance all past treatment received.

56. Revision of some record forms and improvement in the handling of patient records upon transfer or release should be sought.

#### Staff Aspects

57. The present practice of having one full-time dentist work in a region, i.e. two or more close institutions, should be retained but extension of the program will require a fresh look at the effective patient load each dentist can handle. In any case, existing anomalies in dentist supply should be removed.

58. All full- and part-time dentists should have trained dental assistants who would act both as chair-side assistants and do essential secretarial work. A dentist-assistant team would be more productive and thereby partially compensate at minimal extra cost for additional costs of the expanded program.

59. Most dentists have had little or no training in the effective use of chairside assistants so that the organization of additional training for dentists in this regard would be desirable.

60. The Ministry should adopt a pragmatic approach to new dental auxiliaries and should selectively employ new types of trained auxiliaries as these become available and their duties are legalized. Shortly, certain dental assistants will be qualified to perform prophylaxes and topical fluoride applications; such persons could be used very effectively in the training school program. Dental hygienists may soon be involved in the placement and shaping of filling materials in cavities prepared by dentists; however, their employment would only be warranted in multi-offices which at present do not exist within institutions. Dental technologists might eventually be employed under the indirect supervision of the dentist to fit dentures in one institution while the dentist is at his "other" institution doing restorative or surgical work. Fuller use of expensive office facilities would result.

61. In order to compete on the market place for scarce dental auxiliaries, the Ministry would have to adopt the undergraduate bursary support program already used by the Ministry of Health for dental hygienists.

62. Average salaries of dentists should be raised to the level (\$23,000) already supported by the Ministry of Health in its grant program to provide services to selected communities currently without dental services. All salary scales for existing and new auxiliaries should be competitive if good people are to be recruited and kept.



63. The Ministry should employ a full- or part-time preventive dental educator (a dental hygienist or one of the new preventive dental assistants) who would be responsible to develop and carry out a dynamic educational program for small groups. This program which would involve a tailored selection of recent audio-visual material and group participation, would be particularly designed for integration into the educational program of training schools and for selected groups in some other institutions.

64. Association of staff dentists with local hospitals, other institutions or clinics, and where feasible, appropriate university dental departments should be encouraged.

65. An extensive continuing education program for dental personnel should be mounted. The need for extra training in the efficient use of auxiliaries has already been mentioned. Other short courses of a didactic and participatory nature in appropriate preventive and clinical subjects should be identified (or specifically organized) for staff attendance on at least an annual basis. Mandatory continuing education for dentist licensure is imminent.

66. The dental program of the Ministry whether or not significant changes in its dental program are made, would benefit from the part-time employment of a dental consultant. Certainly if any extensive changes are contemplated, the services of a part- or full-time coordinator would be mandatory.

Facilities, Supplies and Equipment

67. Dental program expansion could occur (by more complete use of existing facilities and increasing productivity through effective use of auxiliaries) in a limited way without expansion of office facilities but efforts to expand current office facilities where feasible, e.g. to two dental chairs, would give a more satisfactory end result.

68. In particular, new facilities should be examined carefully, not only in terms of the number of equipped offices but in the arrangement of equipment and cupboards within each office. Many changes in efficient office design have occurred recently and dental companies provide free planning services. The Ministry should insist that these services be used in its negotiations with the Ministry of Public Works about new facilities. Such guidance in the re-design of existing facilities should also be sought.

69. New equipment and cupboards should be ordered carefully with these newer concepts of office design in mind.

70. Improved arrangements for ordering routine supplies should be developed so that current delays are eliminated. The mechanism of a specific dental budget to permit direct ordering by dental staff within this budget should be explored.

71. Since they routinely visit other dental offices to review new materials, etc., a limited number of visits from representatives of dental supply companies to institutional dental offices should also be arranged.

Report to  
Dr. E. H. Botterell  
with respect to  
Health care provided by the Ministry of Correctional Institutions  
with particular reference to  
Problems associated with the use of alcohol and other drugs

W. E. Boothroyd, M.D.  
September 7, 1972

The objective of this section of the report is to provide a set of recommendations which are meant to enhance the capability of the Ministry of Correctional Institutions to help those individuals who become its responsibility from time to time, with particular reference to drug and alcohol problems.

The material on which the report is based has been derived from three main sources of information:

(1) Conversations with individuals - (a) within Correctional Institutions, both staff and inmates, and (b) with other persons who are particularly interested in the treatment of problems related to drug use.

(2) Visits to several institutions, including Brampton Adult Training Centre (including the Neuropsychiatric Clinic); Sprucedale and White Oaks Schools, Hagersville; Pine Ridge School, Bowmanville; Guelph Correctional Centre; Monteith Correctional Centre and Adult Training Centre; Alec G. Brown Memorial Clinic, Mimico; Thunder Bay Jail, and Kenora Jail.

(3) The experience of the author as a psychiatric consultant to certain Correctional Institutions, and as one particularly interested in problems related to the use of alcohol and other drugs.

These recommendations will be preceded by a short theoretical discussion as to the kind of problem presented and a report of some observations which were made in the course of the author's visits.

In the following, the term "drugs" includes alcohol, marihuana, hallucinogens, amphetamines, sedatives, opiates, and substances that are "sniffed".

The taking of drugs of whatever kind and by whatever method, is a form of behaviour. All behaviour can be seen as an attempt of an organism to relate to its environment. The human organism being very complex indulges in behaviour which is the end result of innumerable determinants. These include the "inner" needs of the person, as well as his more obvious biological requirements, at any given time. The needs are determined by past events, the present situation as it is perceived, and the future as it is anticipated. All of these add up to "motivation", a term which is widely used and frequently abused, especially by individuals engaged in attempting to "treat" a fellow human being. Many hours are wasted in a futile attempt to ferret out the motivation which underlies an individual's use of drugs. The implicit assumption is frequently made that an individual decides that, on a given occasion, or for an undetermined time in the future, he will utilize drugs for a conscious end. Such an assumption runs counter to our current knowledge with regard to the reasons for any behaviour, including that which is categorized by society as "delinquent" or "deviant". In the past few years thousands of young people have been asked "why do you use drugs?". The most honest answer would probably be "I simply don't know", though the answer frequently given (much to the distress



of the questioner) is, "why not?".

The experience of being an inmate in a Correctional Institution, or even a student in a training school occupies, in terms of time, a very small portion of a person's life experience to date. The experience itself, however, is sufficiently different from any other which that person has known that its impact is likely to be far out of proportion to the time involved. The individual is faced with a situation which requires a new set of coping mechanisms.

The final effect of this experience on his future behaviour will result from the person's own perception of himself and of his situation, including the significant "others" around him in the past, present, and future. This is a highly idiosyncratic matter, as is commonly observed. One individual perceives a given institutional setting as threatening, fearful, and destructive. Another finds the same milieu secure, rewarding, and helpful. If the setting is designed to be therapeutic in its impact, a program plan will need to pay a good deal of attention to the individual's perception of it, whether this individual happens to be an inmate or on the staff. Success is likely to attend such planning only when there is sufficient built-in evaluation, innovation, and feed-back. Two important items are frequently overlooked, which if attended to would improve the results. These are:- (1) recognition that the inmates themselves are an important part, perhaps the most important part, of the milieu itself, and (2) the fact that, as noted above, the milieu as

perceived by the staff of an institution may be quite different from the same milieu as it is perceived by the inmates. Planning for treatment, therefore, is a very complex business and this is particularly so when the objective is to alter behaviour, such as drug-taking.

Even with the best planning some of the persons subjected to a given treatment procedure will not be helped in terms of their present feelings and future behaviour. For some the "treatment" may turn out to be, in fact, anti-therapeutic.

Only lately has society begun to scrutinize its criteria for separating the bad from the mad and distinguishing between the two is becoming more difficult year by year. Until recently the classification of behaviour into that which was psychologically abnormal and that which was socially abnormal, seemed to provide a useful tool for the construction of appropriate treatment programs. Even that distinction has now lost much of its former attractiveness. Currently the word "treatment" is expected to include all phases of a process which, in the present context, begins when a person is received from a court procedure and does not terminate until "rehabilitation" has been accomplished. In this broad sense every person with whom an inmate comes in contact during his period of sentence, whether inside or outside an institution, can be considered a potential source of treatment. The erstwhile distinction between "treatment person" and "custodial person" falls away and becomes meaningless, even misleading. In addition, as will be pointed out below, those other

persons in the Correctional Institutions who are in the role of fellow inmates will have a profound effect on the individual's behaviour and therefore can be equally considered as involved in "treatment".

It is of value to differentiate both qualitatively and quantitatively between "drug use" and "drug abuse". Society is accustomed to making this distinction with regard to alcohol, though admittedly the borderline between heavy drinking and alcoholism is blurred. The usual distinction is inherent in the definition of alcoholism as "dependence on alcohol to the extent that it has an adverse effect on the physical health, psychological well being, or social productiveness of the individual". The value judgment inherent in the word "adverse" in the above definition is in most cases easily made. The distinction is, however, more difficult with regard to drugs other than alcohol, where value judgments are affected by the novelty of certain drugs and the associated lack of capacity to predict their long term effects. Fortunately the panic which characterized society's reaction to the "drug problem" two years ago has largely subsided and we can think more logically and constructively about the steps that need to be taken to assist those members of our society who have problems related to their use of drugs.

#### Observations

1. All of the staff who were interviewed showed a high degree of dedication to their work.
2. The erstwhile covert (rarely, overt) antagonism between

"correctional staff" and "treatment staff" is now not much in evidence. The commonality of goals shared by all staff is gradually over-riding the potential contradiction between the need to do what is required to "protect society" and the need to do what is best for the individual.

3. With some exceptions, institutional staff members view the use of drugs by inmates as a symptomatic manifestation of underlying problems of a personal and social nature - a concept which is commendable.
4. The prevailing philosophy of treatment for drug problems in Correctional Institutions is a logical extension of this concept, namely, that it is the person which must be helped (treated) rather than undue concentration on behavioural problems with which he presents.
5. This general approach extends, in large measure, to the special clinics (A.G. Brown and Neuropsychiatric Clinic, Guelph) which have been designated as units dealing in particular ways with particular problems. In these clinics, though the emphasis and techniques are different, the objective is to effect "positive changes in the areas of personality, attitude, and behaviour".
6. There is an almost universal desire on the part of staff to become more skilled in their relationship management and more knowledgeable about the whole area of "helping others".
7. There is a less prominent realization of the need to evaluate

the results of their efforts and to discover what indeed they are accomplishing in terms of the short or long term effects on the individuals under their care. Awareness that evaluation techniques are available seems to be lacking. The usual reply to questions in this area relates to what is seen as prohibitive cost in terms of time, personnel, or facilities.

8. There continues to be a strong tendency to regard the inmate as a person who, having failed in his own coping with problems, has thereby demonstrated a need to have someone else run his life for him. The behavioural manifestation of this prevailing staff attitude is to tell the patient what to do, and when and how to do it. Granted that this is appropriate in the work setting of an institution, it is less effective when the objective is to maximize the growth potential of an individual personality.
9. In contrast to the above general attitude, one sometimes encounters the view that the wishes of the inmate should play an important part of the scope and details of any individual treatment plan.
10. There is a growing tendency to encourage and assist inmates to utilize the medical and social services of the community, on discharge.
11. At certain Centres, (for instance, Galt, Brampton, Vanier, Hagersville, and others) staff of the Centres, both professional and non-professional, have been engaged in highly productive counselling programs.



12. The current emphasis on development and expansion of community relationships is popular with both inmates and staff. However, there are many practical difficulties and these are gradually being recognized and faced. A prominent example is the relationship between Correctional Institutions and local health facilities, e.g. hospitals, out-patient clinics, social agencies.
13. The establishment of Citizens Advisory Committees at regional detention centres provides a potential increase in the treatment resources available while the inmate is in an institution and, especially, thereafter.
14. In many units a mutually helpful relationship has been developed with local branches of the Addiction Research Foundation. This usually takes the form of assistance in staff training and in case consultation, which activities the staff of the Foundation is well able to provide. In return the statistical data made available by Correctional Institutions, particularly jails, are of value to the epidemiological research carried on by the Foundation. Examples of areas where there is active collaboration are: Ottawa, London, Toronto, St.Catharines, Welland, Brampton, Kenora, and Monteith. An example of an area in which more collaboration might be profitably developed is Guelph.
15. Several courses have been conducted over the past three years, aimed at the Superintendents of Correctional Institutions, Probation Officers, senior Jail personnel, etc. These courses have been well attended and well received.

16. A proposal recently put forward by the Lake Erie Region of the A.R.F. consists of the following three phases:

Phase 1. Attendance by jail superintendents and/or assistant superintendents at one of the summer schools being conducted twice each year and sponsored jointly by the Addiction Research Foundation and a University in Ontario.

Phase 2. Two identical two-day workshops, one month apart, to be conducted in the late Fall of 1972 in the region. This workshop would deal with the biological sociological and psychological aspects of chemical dependencies along with consideration of practical solutions to practical problems as they are encountered in jails.

Phase 3. Ongoing consultative service by the A.R.F. to jail superintendents and their staff.

17. In the St. Catharines-Welland area, the staff of the two jails had a series of discussions with Addiction Research Foundation staff, with the aim of developing increased competence in working with individuals suffering from problems related to the use of alcohol or other drugs.

18. An outstanding example of inter-Ministry collaboration is being carried on at the Monteith Correctional Centre. Inmates from

the Centre attend a "Day Care Program" at the Northeastern Regional Mental Health Centre at South Porcupine, which has made its facilities available for this purpose. The Addiction Research Foundation is responsible for the research aspects of the program. The expenses are divided between the Ministry of Correctional Services, the Ministry of Health, and the Addiction Research Foundation.

19. With regard to the requirements for staff training, with particular reference to alcohol and other drug problems, there appear to be three possibilities at present:

- (a) Two-year courses offered by certain colleges (e.g. Sheridan and Centennial), which, while desirable, are quite impractical for a large majority of staff personnel;
- (b) Very short (one day to one week) courses offered from time to time by the Addiction Research Foundation and other agencies such as Mental Health Canada;
- (c) In-service training programs consisting of on-the-job supervision by skilled supervisors, with or without some additional one-a-week didactic sessions ranging from 1-3 hours in length.

Courses of intermediate length, say one to two months, apparently are not available at present. These could probably be arranged either within the Correctional Services itself or by other training resources in the community.

20. There is a prevailing impression that in most cases inmates' sentences are too short to permit significant impact of any treatment program, particularly with reference to such "chronic conditions" as alcoholism or other drug dependencies. An apparent contradiction to this general feeling is the policy which, in some cases, restricts treatment at the Alec G. Brown Clinic to the latter part of a long sentence.
21. A tremendous and largely untapped source of treatment personnel is to be found within the inmate population itself. The Institute for the Study of Crime and Delinquency in California recently conducted a study entitled, "New Careers Development Project". "Change and development teams" were established which included both professionals and non-professionals (inmates). The non-professional members of these teams were carefully selected and trained to focus on work with task-oriented groups, but not as therapists or researchers. The results of this interesting experiment would seem to be worth careful study with a view to modification and implementation in Correctional Institutions in Ontario.
22. Courts have the power to stipulate "treatment" as a condition of probation, and this practice is apparently becoming more common. The administrative difficulties that arise in the implementation of such a procedure are formidable but not insuperable. They require careful consultation and cooperation among the parties concerned.

Similarly, making a treatment a condition of parole tends to ensure attendance at treatment programs. There are both advantages and disadvantages inherent in this kind of "constructive coercion". Careful experimentation and assessment in this whole area is much to be desired.

23. The medical and psychiatric facilities in institutions, and available in the local community, should be adequate to care for the physical and psychiatric complications which occur in a small proportion of alcohol and other drug users. These include local and systemic infections arising from intravenous self-medication, hepatitis, cirrhosis of the liver, polyneuritides, psychotic episodes, chronic brain disorders, and other infrequent complications.
24. In November, 1970, Surridge and Lambert conducted a survey of drug use among wards prior to admission to Ontario Training Schools. They reported that 54% had used at least one of: marihuana, LSD, solvents, speed, opiates or "other drugs", seven or more times in the six-month period prior to their admission. They also noted that this proportion is very much higher among young people admitted to training schools than it is among students in the community. There was an increased incidence of drug use among wards who came from large cities compared to those who came from rural areas. Seven percent claimed to have used all these substances, as well as cigarettes and alcohol. The authors



state that the wards "did not generally perceive drugs as being harmful but the fact that some recognized the dangers did not prevent them from using drugs".

25. The following quotation from Hansard reports a statement by the Minister of Correctional Services in the Ontario Legislature on 24 April, 1972:

"Another aspect of our contribution to the government's overall plan for the provision of services to deal with chemical abuse was the expansion during the year of our educational and counselling programs. Additional complement for this purpose was provided at a number of institutions, and a drug addiction coordinator, working out of the Brown Clinic, was appointed to give assistance and guidance to this program".

#### Recommendations

Responsibility  
for Program

1. That one senior member of headquarters staff be designated as the person responsible for ensuring that the best possible care is provided throughout the Ministry for inmates/wards who have problems related to drug (including alcohol) use.
2. That each institution establish a drug and alcohol committee with one or more professional and non-professional representatives from staff and community; and that the general term of reference

of this committee be to advise the superintendent with respect to the program within that institution for the provision of care for inmates/wards who have problems related to drug (including alcohol) use.

Reporting

3. That regular (yearly?) reports be requested from all superintendents as to what is being provided in their respective institutions for inmates/wards who have problems related to drug (including alcohol) use.

Staff Training

4. That all staff receive, as part of their pre-training and/or on-the-job training, instruction with regard to the provision of appropriate care for inmates/wards who have problems related to drug (including alcohol) use.
5. That the instruction mentioned in 4 above incorporate the principles outlined in the earlier parts of this report.
6. That provision be made for the attendance by selected staff at courses, training sessions, work exchanges, etc., which are frequently available outside the Ministry itself, at universities, clinics, other treating agencies, etc.

7. That the proposal put forward by the Lake Erie Region of the Addiction Research Foundation (see para. 16 of Observations above) be implemented, evaluated and, if deemed successful, emulated in other areas and centres.
8. That consideration be given to the establishment of courses of one to two months' duration either within the Ministry or by other training resources in the community. Such courses would require full time attendance and a mixture of didactic and experiential training for the candidates. Attendance at such a course would necessitate adequate administrative arrangements within the institutions themselves in the form, for instance, of extra staffing to take over the duties of those who are on course from time to time.
9. That factual information, in written form, about drugs (including alcohol) be made readily available to the staff and inmates/wards in every institution and that both staff and inmates/wards be actively encouraged to increase their own information about these substances, and their effects, by recourse to this educational material.

Educational  
Materials

Addiction  
Research  
Foundation

10. That the personnel and other resources of the Addiction Research Foundation be maximally utilized for the purposes of training, consultation, and as a source of educational materials for both staff and inmates/wards.

Liaison with  
Local  
Communities

11. That close liaison, both official and personal, be established between each correctional institution and the other health-care agencies (e.g. hospitals, clinics, welfare agencies, etc.) in the local communities.

12. That full use be made of volunteers, voluntary organizations and groups in the community (e.g. Alcoholics Anonymous, church groups, concerned individuals) for the provision of care for inmates/wards who have problems related to drug (including alcohol) use, during and after their stay in an institution.

Alec G.  
Brown  
Clinic

13. That the primary goal of the Alec G. Brown Memorial Clinic be: to develop, enhance, and disseminate knowledge about the care of inmates/wards who have problems related to drug (including alcohol) use. Accomplishment of this goal will include (but not be confined to)

achievement of the following objectives:

- (a) Critical evaluation of the "treatment methods" presently in use in the Clinic itself, and in all other correctional institutions; (for a diagrammatic representation of the treatment-research problem, see Figure 1 attached).
- (b) Development and testing of model programs which are effective and feasible for local institutions.
- (c) Participation in the relevant education of staff throughout the Ministry.

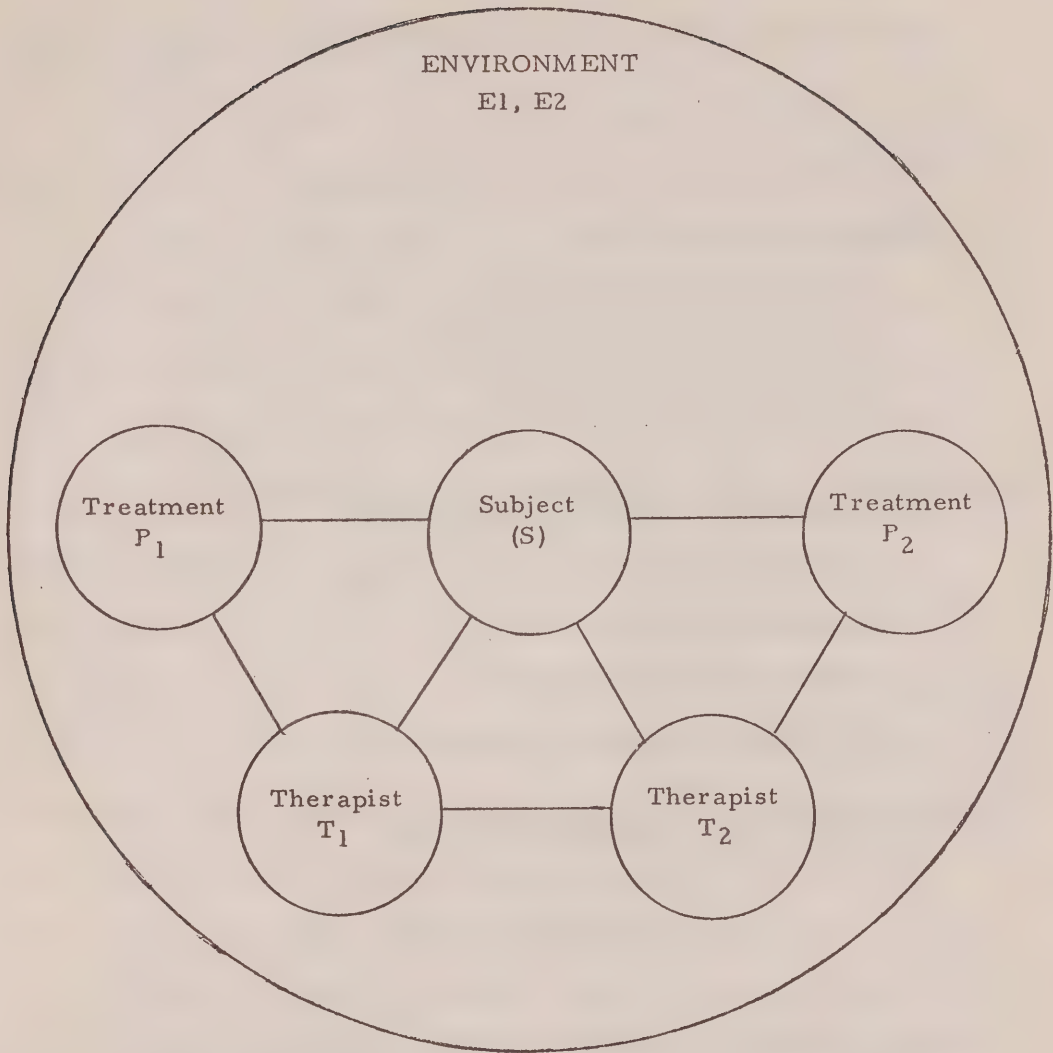
This primary goal does not exclude the other activities of the Clinic, as, for example, its important work in the area of sexual deviations.

Monteith  
Project

- 14. That the Monteith Project (see para. 18 of Observations above) be vigorously supported, as heretofore, with modifications from time to time, always consistent with a strict research protocol; and that opportunities be sought to establish treatment-research projects in other carefully selected centres.



Figure 1



$$P = f(R_1, R_2 \dots R_n) ? (T_1, T_2 \dots T_n) ? (S_1, S_2 \dots S_n) ? (E_1, E_2 \dots E_n)$$

WHERE  $R_x$  = Essential treatment elements  
 $T$  = Essential characteristics of therapists  
 $S$  = Essential characteristics of subjects (patients)  
 $E$  = Essential characteristics of environment  
 $?$  = Unknown relationships +, -,  $\div$ , x, time  
 $.$

REPORT ON ETHICS IN HUMAN EXPERIMENTATION

INTRODUCTION

A. LEGAL CONSIDERATIONS

- 1) The Nature of the Contract
- 2) The Nature of the Experiment
- 3) The Experimental Subject

B. GENERAL ETHICAL CONSIDERATIONS AND THE  
METHODOLOGY OF EXPERIMENTATION

- 1) Substitution for Human Experiments
- 2) Strategy in Research
- 3) Stressful Investigations
- 4) The Choice of Human Subjects

C. CONCLUSIONS AND RECOMMENDATIONS

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From: A Committee on Experimentation on Human Subjects

Members: Dr. G.M. Brown  
Dr. A. Bruce  
Dr. S.G. Lavery (Chairman)  
Dr. S.L. Vandewater  
Dr. D.N. White

For: Dr. E.H. Botterell,  
Dean, Faculty of Medicine,  
Queen's University,  
April, 1964.

(Signed) S.G. Lavery

REPORT ON ETHICS IN HUMAN EXPERIMENTATION

INTRODUCTION

Two views concerning ethical practices and experimentation on human subjects are commonly stated. The first view is that decisions concerning ethics should be left to the conscience of the individual scientist, because he is likely to be better informed about his experiment and its relevance than anyone else. The second view is that the experimenter should share his responsibility and his plans with a responsible and impartial other person or body. Legally, and employing authority is liable to share the responsibility for the actions of its employees in a master and servant relationship (1). At the present time, the majority of people employed in human experimentation are employed in this capacity by universities, research granting bodies, government departments, or privately owned industries. These employing agencies may be protected by insurance policies against risks incurred as a result of experimentation. Since such experimentation on a large scale is a comparatively recent phenomenon, judicial decisions defining and limiting its lawfully accepted practice are few. From decisions that have been made and from the opinions of legal experts, it is possible to outline probable situations that might confront an experimenter whose work had led to legal action being taken against him. These points are discussed below under A. Legal Considerations.

A standard of ethical practice requires more than the observance

of a legal protocol. The word "humanity" is used in a double sense to assert the fact that in mankind there is a highly developed capacity for social cooperation, which has become progressively developed and refined to decrease suffering and promote friendly and constructive human relations. A contrary and destructive point of view also, of course, exists and at times flourishes. It is reasonable, however, to assume that the majority of experimenters are highly concerned and motivated to treat their subjects with all humanity possible, and that they would oppose and prohibit experimentation carried out with destructive and sadistic intentions. The conduct of human experiments therefore requires the development of methods which satisfy the concept of "humanity". They are discussed under the heading B. Ethical Considerations.

#### A. LEGAL CONSIDERATIONS

##### 1. The nature of the contract

The research experimenter and his experimental subject stand in a similar relation to that of the physician and his patient (2). The essential difference is that the experimental subject has not employed the doctor, nor does he expect a benefit from him. Rather the subject has been employed and may, in fact, have been paid. The question of payment is not considered to have any bearing on the status of the experimental subject in relation to any claims he may make against the experimenter. The experimenter and the subject are expected to share a common commitment against disease, or at least a belief that the experiment will be of value, if not to the subject, to others, and yield

"a common benefit not obtainable by other means" (3).

It has been stressed that the experimenter should be a medical practitioner whenever medical procedures are carried out as part of an experiment, medicine being "the profession that is trained more completely than any other in comprehending somatic and psychological aspects of human life, be it healthy or diseased" (4).

Consent. The voluntary consent of the human subject is absolutely essential (5). This is the first rule of the Nuremberg Code, which although, strictly speaking not a normal legal precedent, lays down certain basic principles which should be observed in order to satisfy moral, legal, and ethical concepts. The rule of consent was amplified as follows: "This means that the person involved should have legal capacity to give consent; should be situated as to be able to exercise free power of choice without the intervention of any other method of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration, and purpose of the experiment; the methods and means by which it is to be conducted; all hazards and inconveniences reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent will rest upon each individual who initiates, directs, or engages in the



experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."

For this reason a consent form should be prepared, showing what has been described to the subject and bearing his signature along with that of a witness. The obtaining of the consent, however, does not protect the experimenter from actions which may be brought against him. It is in his favour, however, that he can be shown to have acted in accordance with the details set forth.

The interpretation of the probability of risk, of the phrase "reasonably to be expected", would refer to the experimenter's previous experience with the risks involved and what general knowledge was to be had of these risks.

The act of consent in minors and the mentally ill has been subject to special comment (6). "The ethical principles involved in the use of the mentally incompetent are the same as for mentally competent persons. The only difference involves the matter of consent. Since mental cases are likened to children in an ethical and legal sense, the consent of a guardian is required". Consent cannot be given to criminal act and no subject has the right to consent to the infliction upon himself of death, or of any injury likely to cause death, except for necessary surgical purposes. This may be extended to the impropriety of consent to an act that will cause any kind of harm definable within legal concepts. It is clear that there has to be a weighing of risks against the benefits to be obtained. In the case of medical treatment these benefits can be reasonably stated, but in the case of experiments some uncertainty must accompany each phase of experimentation and the researcher must rely to a large extent on his own judgment.

Withholding information while obtaining the consent of the subject has been defended in certain special situations, to protect the patient's morale (7), or in the prescribing of a controlled treatment (8), or the carrying out of an experiment whose purpose is concealed by intention from the subject (23) but in these cases, all contrary to the legal ruling on consent, no special provisions have been laid down.

## 2. The nature of the experiment

The Nuremberg Military Tribunals laid down ten rules concerning experiments on human subjects which are paraphrased below.

1. The voluntary consent of the human subject is absolutely essential.
2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.
4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.
6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.
8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.
9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Beecher (2) has pointed out that rules such as these may not be easy to apply to many important situations. For example, rule 3 implies that the anticipated results will, in fact, justify the performance of the experiment, whereas most experiments are conducted to test this prediction. Similarly "random" and "unnecessary in nature" (rule 2) are hard to define and could probably be applied to many experiments in their initial stages, which later became fruitful and of value. Roxburgh (9) points out that experiments differ in their aims, some being to improve a patient's condition or to help others similarly afflicted, and others to assess responses of subjects to a specific situation or stress. It is in this latter group that experimentation has been most criticised. When treatment is an associated aim of the experiment, the phrase "observations in the course of treatment" appears applicable. Experiments which are not directly designed to confer benefit may be interpreted as malpractice. Accepted standards for experimentation are not clearly laid down. Ladimer (3) has expressed the need for such standards. "Properly conducted experimentation in man by qualified scientists must therefore be considered an integral part of biologic and medical science, but it does not thereby become customary medical practice, nor does its essentiality and acceptance establish clearly its character, or place the methods employed beyond scrutiny. The responsible professions have a duty to delineate for their own members and for a critically vigilant public, the nature of medical research and the limits within which it may be properly undertaken".

Ladimer also defines standards for clinical research: "A physician in regular practice may reasonably be tested by his use of accepted measures in a specific situation. In research, standards must relate to how the investigator proceeded and how he checked himself. The means by which research of high quality is being managed and the safeguards employed to protect the subject can be generalized into a set of precepts similar to that governing malpractice to serve as a guard. Thus wilful or negligent deviation resulting in injury, would constitute a basis for liability. On the other hand, observance of all known precautions, even in the event of untoward result, would protect the honest, qualified investigator. Neither he nor the physician is a guarantor of success, but each has a responsibility to his own law and credo".

The medical and social need for an experiment has to be judged in relation to the risks entailed. It is unwise for the experimenter to judge the need for the experiment himself alone. He should appreciate the need for an outside opinion for the assessment of risk, an outside opinion unlikely to be carried away by the natural enthusiasm of the research worker. Beecher (10) proposes that where there is even a remote hazard, group decision, supported by a consultative body should be employed. Guttentag (4), suggests that the physician-experimenter should be guided by a physician-friend "not interested in the scientific outcome of the experiment".

Ladimer (11), states the position taken by strict legal writers and jurists; "experimentation is not the duty of the physician and, in fact, the doctrine has been "the physician experiments at his peril"". Ladimer proposed that experimentation be recognised as a legitimate scientific



endeavour which can be advanced by the recognized research scientists. The legal issue would then become, not experimentation versus accepted practice in the art of medicine, but an evaluation of the plan and conduct of research in relation to specific fact situations, i.e. whether the research was conducted with due regard to the interest of the subject. "The law has a duty to comprehend the scope and elements of diverse human activities and their places in society, if it is to assist in making individual judgments and setting or recognising general values. Essentially medical research on human beings consists in experimentation, that is deliberately inducing or altering bodily or mental functions directly or indirectly, and individual or in groups, primarily for the advancement of health, science and human welfare" .... "The conduct of medical practice, generally conceived to be diagnosis, treatment, and care, is governed by statutes and supporting administrative licensing, and regulatory bodies. Medical research in human subjects, except as an inherent but not predominant incident of such practice, would appear to be outside the scope of medical practice. There is no existing broad police power statute for control of human research, although it is by its nature subject to the general police power". Such propositions require incorporation into judicial decisions to become an effective part of the law.

As a result of experimentation, either civil or criminal actions might be brought against the experimenter. A civil action may arise as the result of an accusation of assault or trespass to the person in the absence of injury. The accusation of malpractice or of negligence may be brought. It is of prime importance that provisions and precautions for the safeguard of the subject should have been made, and that means of resuscitation and of



emergency treatment should have been at hand. Nevertheless, without negligence, an experimental procedure may by its nature have an unknown and relatively unpredictable outcome, as a result of which death or injury may result. It is in this case that the subject's having given a consent valid in law, and having had a full understanding of the nature of the experiment, would be emphasized. Also, in this case, the aims and purpose of the experiment would be critically weighed against the risk involved. The greater the risk, the more embracing the explanation required. (12)

### 3. The experimental subject

It is required legally that the subject should be a volunteer and that he should understand the nature and extent of the risks involved. A division of opinion appears to exist as to whether a person who is not competent to understand the nature of the experiment can be made an experimental subject by the consent of a guardian. The choice of experimental subjects is further discussed. (v.i.)

Legal considerations in relation to Canadian law. In a recent case of alleged trespass (13) judgment was given to the defendant although a valid consent had been obtained and prior consultation concerning the experiment had been undertaken.

Personal communications given to this committee by members of the Faculty of Law at Queen's University, (Prof. Lederman, Prof. Ryan and Prof. Mewett) and from Mr. B. Cunningham (legal advisor to Queen's University), confirmed many of the above points drawn from published literature in the light of current Canadian legal practice. The following aspects were emphasized.

"Care must be taken to assess the capacity of the patient or subject to give consent, and to see that he does appreciate the nature of the experiment and the risks involved. It is expected that the explanation will be full and detailed in proportion to the possible dangers. An altruistic motive is expected in both the experimenter and the subject and no other motive is necessary. It is expected that a reasonable level of experimentation can be carried out for public benefit. Where experimental subjects show willingness to sacrifice themselves without duty or obligation, it is clear that limits should be placed on their altruism, particularly where the risk is great, where eligibility for consent, or capacity for the assessment of harm is in doubt. There is a liability in all cases and a civil responsibility if anything goes wrong that will harm the subject. Severe risks are unlikely to be commensurate with possible gain. It should be possible in experiments to show on a scientific basis reasons why the experiment should be expected to work. The seriousness of the condition or the urgency of the problem towards which the experiment was directed would affect judgment, as it affects the individual and as it might affect humanity in general. A clear record of what was said to the experimental subject in way of explanation should be kept and form the basis of the consent form. The capacity for appreciating the situation as explained to the subject, that is the intelligibility of the explanation, would be judged according as to whether it was understandable by a "reasonable man". It would be helpful to have a witness present who was able to say that the subject "appeared to understand clearly". In the case of subjects who already stand in a subordinate relation to authority or to the experimenter, such as prisoners, students, junior members of

staff, members of the armed forces, it is important that freedom of choice be explicit and that no threat, benefit, or inducement should be present. Nevertheless, payment given to such subjects and to experimental subjects in general is unlikely to influence judgement. In the case of certified patients or minors who are incapable of consent, experiments can only be carried out which are for the benefit of the patient. When ordinary procedures are carried out on patients in hospitals which are being used for research, and where the doctor uses the moral authority of his role as the patient's own doctor, it is still wise to ask for consent and to give the subject a proper appreciation of what is being done. The waiving of this confidence might be defended if it was for the potential benefit and welfare of the patient. Where placebo treatments or borderline treatments are being given, the patient should be told of the hazards, if at all perceptible".

## **B. GENERAL ETHICAL CONSIDERATIONS AND THE METHODOLOGY OF EXPERIMENTATION**

Biologists working with experimental animals have sought to develop methods and techniques which will reduce the unpleasant aspects of experimentation to a minimum (14). It will be recalled that at the beginning of this century public protest was largely directed towards experimentation in animals. At that time, experiments in physiology and pathology were criticised. Since then much has been done to lessen the suffering of animals in experiments and to improve their living conditions. Today, criticism might justly be levelled against the clinician, the experimental psychologist and psychiatrist who may expose human subjects to dangerous or stressful experimental situations.

The antagonists of vivisection were chiefly concerned with the suffering of animals, whereas in relation to human experimentation the question of death or bodily injury has been the central issue. The question of human suffering must now be considered.

It is probable that for each area of scientific investigation there are experiments which by their very nature are productive of pain and suffering. Such areas of knowledge may require to be investigated, but experiments should certainly not be carried out in search of results of uncertain general value, and answering no better question than "What happens if. . . .?"

It is ironical that in the century during which methods of relieving suffering have been developed to a high level, man's inhumanity to man has also been practised on a scale unprecedented in history (22). Sophisticated techniques have been used for both good and evil. The conscience and intentions of the experimenter; the experimenter's respect for the subject and his rights as an individual must be made quite public. The abuse of experimental procedures in the hands of the medical profession is, of course, more likely to derive from negligence and carelessness than from malevolence. However, the use of special techniques for controlling and converting individuals (15, 16) has been so readily exploited by those in power who are concerned to suppress individual freedom and criticism, that it has become a prime duty of the experimenter to avoid contributing to callousness. Suffering produces anxiety and resentment. It can be reduced by attention to experimental technique and in the selection of experimental subjects. Some suggestions are appended.



# 1. Substitution for human experiments

Where possible, animals should be used as experimental subjects rather than human subjects. It is possible that in long-term investigations tests may be made to indicate whether animal experiments can be used to predict the outcome of the same experiments conducted in humans. The use of human subjects can thereby be minimized. Also the use of models, such as 'dummy-men', chemical or electronic apparatus, computer programs, has been proposed as an alternative to using human subjects. The use of such systems is not expected, of course, to produce extreme fidelity but they may serve to expose logical flaws in the development of theory. As put by Russell (17), "we may need the animals themselves, as it were, on the night; machines will do very well at rehearsals".

Two ways in which the model may differ from the original have been described by Russell as 'fidelity' and 'discrimination'. 'Fidelity' implies that the overall properties, 'discrimination' that a particular property, of the original, is well reproduced. Lack of overall fidelity need not be an obstacle to using animal or other model research, provided it has been shown that there is good correlation between results in the model and results in the human. Parallel results are in themselves adequate grounds for choice of a model. Rules for the use of such models are in the course of development (14).

A special example which requires the use of a model of very high overall fidelity is that of the testing of the toxicity of drugs. Clearly such testing has to be carried out on species closely related to man before finally being tested on human subjects themselves. Toxicity testing in-



volves a testing of already known preparations for quality control and the screening of new compounds. "The investigation of the toxic and other effects of new drugs in experiments on non-human subjects might be carried much further in an attempt to gain better predictions as to the effect of these drugs on humans". (14)

## 2. Strategy in research

Research which is based on trial and error may be wasteful of subjects. The alternative of "testing deductions from well and consciously formulated hypotheses (or hunches)" usually results in particular experiments being selected on a restricted basis from a larger set of experiments which could have been performed. This method is less wasteful of subjects with a possible gain of information. The proper use of comparative data may also prevent unnecessary re-duplication of experiments. The statistical design and analysis of experiments allows a proper estimate of the numbers of animals used in the experiment to be made in terms of the precision of the results. The necessary minimum can be specified.

The proper planning of experiments, therefore, can be expected to reduce the number of necessary subjects (18). "Failure to make some of the planned observations is a common misadventure in many experimental procedures"... "It is an elementary principle for the experimenter, not himself a statistician, to seek statistical advice before experimenting" (14).

A further point in relation to experimental design is that of control of variation in the experimental subjects. A systematic study of the factors affecting any particular experimental variable can lead to better selection of subjects; better control of the relevant variables, and a

reduction in numbers necessary.

### 3. Stressful investigations

It is clear that the imposition of pain and distress is likely to prove an interfering factor complicating experimental results. It is, therefore, absolutely in the interests of the experimenter to reduce these elements to a minimum. When stressful effects themselves are the subject of experiment, they should be controlled and where possible, the effects of small stresses should be studied in preference to those of large stresses. Even in this area, it may be possible to study the effects of stress without causing the subjective experience of stress. Many techniques causing discomfort and distress could be better practised under various forms of sedation or anaesthesia. Even routine techniques such as taking of blood show great variation in relation to the causing of distress. Capitalization on naturally occurring experiments is, of course, an integral part of clinical science. Careful field work may sometimes be more profitable than controlled work in the laboratory and more relevant. Russell and Birch quote an experiment (19) which illustrates how careful preparation and thought can make an experiment which at first sight seemed to pose insoluble problems and to suggest stressful procedures, yield by the use of humane and non-punitive measures. "it is clear a fortiori that in less exact investigations, the freedom of choice of the experimenter is often very much wider than at first appeared. The full use of this freedom is the mark alike of humane and successful experimentation" (14).

### 4. The choice of human subjects

Beecher (2) states that subjects who clearly should not be subjects

of experiments are those "who may die suddenly or seem to be in imminent danger of death". This should hold however harmless the planned procedure may be, for "if death occurs during such an experiment, it may cast a shadow over a potentially valuable agent or useful technique, not to mention placing the investigator in a most unhappy predicament, where, although innocent, he may appear guilty".

Beecher also suggests that it is usually unwise to study a therapeutic procedure in an individual who has a disease unrelated to the expected therapeutic effects.

Patients who are suffering from the disease or syndrome under investigation make, of course, proper subjects for experimentation but this does not permit a suspension of the rules of consent and explanation.

It should be realized that lay subjects, sick and well, often do not understand the implications of complicated procedures even after careful explanation, and because of the special relation of trust existing between patient and doctor, most patients consent to any proposals that are made. This lays an inescapable responsibility for determining what investigation should be undertaken with the doctor concerned.

The use of laboratory personnel and medical students has often been made but Beecher points out that in a sense these subjects are captive and may experience a special inducement or coercion and that their sophistication in the understanding of the experiment may be a hazard to the experimental conclusions rather than an asset. Similarly, the possibilities for direct or indirect coercion in the use of civil prisoners may preclude their use.

Highly neurotic subjects and those who are volunteering for experimentation in order to prove their capacity to tolerate distress, or those who appear to be overenthusiastic in self-sacrifice, are best avoided as subjects of experimentation. Hogben and Sim (20) have suggested that volunteers might be called upon to take part in experiments in the same way as blood donors are recruited. Such groups are to be found, according to Beecher, amongst conscientious objectors to military service and in the ranks of the Mennonites, both of whom volunteer as subjects for scientific studies.

#### C. CONCLUSIONS AND RECOMMENDATIONS

Guidance may be had concerning experimentation from general legal principles, and the application of careful judgment weighing potential risk against valid scientific curiosity. In the absence of clear legal statutes, the United States Public Health Service has in effect adopted the Nuremberg Code's ten points with added comment on the importance of group approval of all procedures when even remote possibilities of hazard exist. The rights and welfare of the patient and experimental subject are emphasized. "An overriding principle guiding all clinical studies is that the welfare of the individual human beings takes precedence over every other consideration. Medical procedures or therapy substantially different from accepted general medical practices are often an essential component of clinical medical research. This offers the only means of acquiring certain information necessary to solve the problems of the diseases and disorders

that afflict man. Ethical and scientific considerations dictate, however, that these investigations must be undertaken only after mature thought under rigorously defined and controlled conditions and under circumstances that will minimize the dangers of predictable or unpredictable hazards. The basic principle on which all such investigations must rest is that human beings have inalienable rights that supersede all other considerations that may be raised in the name either of science or of the general public welfare. The responsibility of the physician for the physical and mental well-being of the persons in his care and for observance of the ethics of his profession cannot be overridden by any element of study or research that is interjected into the relationship between the physician or surgeon and persons in his care (21).



## RECOMMENDATIONS

1. Persons engaged in experimental research on human subjects should be expected to seek appropriate consultation and group support for their work. If approved by the faculty, a special panel within the faculty might be set up who would be prepared to review and advise on matters concerning the propriety of a particular research project. This might also be extended to include persons competent to act as advisers in research design and analysis.
2. Experimental procedures should be carefully explained to the subject, and consent should be registered in writing, showing what was consented to, and witnessed.
3. Precautions against risk and methods of preventing discomfort or suffering should always be sought in experiments where these factors exist.
4. Methods of resuscitation should be on hand where experimental procedures are practised, as they would for clinical procedures.
5. Records of experiments should show any deviations from what is expected that might bear on the later development of complications or untoward effects on the subject.
6. Following experimental procedures adequate supervision and follow-up should be ensured the subject until any reasonably expected danger is past.

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SAMPLE REPORT OF A PUBLIC HEALTH INSPECTION

Inspection of a Correctional Institution

Institution:

Address:

Superintendent:

Inspected by: Mr. Wm. J. Hogle, Consultant, Public Health  
Inspection, Local Health Services Branch and  
Mr. L.I. Dodgson, Consultant, Public Health  
Inspection, Central Region, Local Health  
Services Branch

Date of Inspection: June 28, 1972

SUMMARY

When visited on June 28, 1972, the institution supported an inmate population of 35 through a staff complement of 30. Several structural changes have been effected since the previous inspection and these have generally enhanced conditions.

The staff lunch room has been converted to office space, with new staff facilities, finished and furnished, provided on the third floor. Renovations to the former coal bin area in the basement have resulted in a most satisfactory document storage room. The former staff locker room has been converted to a prisoners' holding room. Here, floors are finished in quartzite epoxy and walls are painted concrete block. Utility sinks have been installed on each floor in the cell block area.

In addition, an eight bed ward on the third floor has been created as a dormitory for the "temporary absence program". Furnishing of this area, which is already occupied, will be completed shortly with the provision of individual bedside tables.

I. PROGRESS MADE ON PREVIOUS RECOMMENDATIONS  
INSPECTION OF DECEMBER 14TH, 1971)

1. That the ventilation in the administration and visiting areas be drastically improved. Serious consideration must be given to improvement of ventilation in the basement workshop.

Action - Not implemented. An air tempering system is reported under consideration.

2. Replaster the damaged ceiling in the women's isolation corridor.

Action - Not implemented. Roof problems are of continuing concern. Viable structural repairs must precede plastering activities.

3. Renovate and put back into service kitchen grease trap, or alternatively, make proper changes to by-pass the grease trap and seal off unused plumbing connections.

Action - Implemented. A new grease trap has been installed.

4. Provide ventilation to the ground floor janitor's room.

Action - Implemented. An extractor fan has been installed.

5. That the water closets in the receiving area and overnight cells be cleaned and repainted with a suitable paint available for that purpose.

Action - Implemented. This recommendation has been dealt with inasmuch as continuous repainting of these fixtures is an ongoing activity. Painting, however, is not the solution and the installation of a new type of toilet, to eliminate the problem, is planned.

II. OBSERVATIONS

(a) Kitchen

A heavy mould growth was noted on the ceiling of the "prepared food walk-in refrigerator" which was operating slightly over temperature at 42° F.

The toilet room door in the food preparation area was open and without a self-closing device.

Surfaces of the wooden cutting table were cracked and badly split, particularly near the rinse sink. Miscellaneous articles including brushes, hampers and burlap were observed beneath this work table.

Several areas of the kitchen were untidy and irrelevant materials such as playing cards and ash trays were in evidence.

Food staff were without headgear.

Separate handwashing facilities are not provided for food handlers in the kitchen.

(b) Laundry

Wooden slat pushcarts are used for both the collection of soiled laundry and the return transportation of clean laundry. These carts are identical in appearance and it must be assumed that functional separation of "clean" and "dirty" carts is not practised. Additionally, the construction of these conveyances precludes proper cleaning and disinfection.

A potential cross-connection was observed at the laundry tub where a rubber hose connected to the taps was hanging below the flood level of the fixture.

(c) General

Common cups were observed in the "temporary absence dormitory" and in the staff kitchenette.

In some instances peeling paint was noted in the shower cubicles serving cell blocks.

Recommendations

1. Improve ventilation in the administration and visiting areas. Serious consideration must be given to improvement of ventilation in the basement workshop. (Repeat)
2. Implement the necessary roof repairs and replaster the damaged ceiling. (Repeat)
3. Eliminate the mould growth in the walk-in refrigerator.
4. Provide a self-closing device on the washroom door serving the kitchen.



5. Repair or replace the wooden cutting table in the kitchen.
6. Improve housekeeping practices throughout the kitchen and remove all miscellaneous and irrelevant equipment and materials.
7. Provide separate, fully equipped handwashing facilities for food service staff in the kitchen.
8. Ensure that all food service staff wear suitable headgear.
9. Replace the wooden pushcarts used for laundry handling with equipment possessing smooth and non-absorbent surfaces. Identify carts according to use. Clean and disinfect carts daily.
10. Eliminate the plumbing cross-connection at the laundry tub.  
(This condition could be satisfied through the installation of a wall clamp to support the hose when not in use.)
11. Eliminate the use of common cups throughout the institution.

WJH/db

(Signed)

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Wm. J. Hogle

COPY OF PHARMACIST'S REPORTTHE PHARMACY DEPARTMENT  
TORONTO JAIL

The pharmacy is defined as the central area in the institution where drugs are stored and issued to various hospital departments and where prescriptions for inmates are dispensed.

The purpose of the pharmacy department is to carry out the pharmaceutical functions in accordance with the philosophy and objectives of the institution.

The pharmacy department and the nursing staff each have specific responsibilities with regard to handling of medications. Although the nurse's primary role is to administer the medicine, she is usually required to perform a number of procedures concerned with the drug order before the medication reaches her hand.

The drug distribution system employed at the Toronto Jail is an "individual patient order" (prescription) system with a slight refinement of this method to a "unit dose distribution". Briefly, it is defined as a system whereby each dose of medication for each patient is prepared in the pharmacy and sent to the nursing station a short time prior to administration (the pharmacist prepares in his working shift the medications required for a 24 hour period).

The basic equipment involved are:

- 1) 2 trolleys on wheels with locks, and compartments for the prepared medication trays.
- 2) Medication trays with individual compartments.
- 3) 1 oz. paper cups (or plastic).
- 4) The individual patient medication tickets prepared by the nurse on COLORED cards. This is the "big key" to the system. The ticket bears the following information: name, date, medication and strength, dose, frequency and duration, and location of patient.

Explanation of the coloured cards:

green - for morning dose  
 blue - for twice daily - but not a narcotic or  
           control drug  
 red - for twice daily - this being a narcotic  
           or control drug  
 yellow - for three or four times daily  
 white - for bedtime

Since red is the color used to indicate a narcotic or control drug, the corners of any green, yellow or white card are notched red to indicate this. The complete red card on a twice daily dose indicates this and thus requires no notching.

For every order, there will always be two medication tickets prepared: 1) a green A.M. card, and 2) a corresponding blue, red, or yellow card. There are two exceptions:

- 1) medication given once daily in the A.M. (a green card);
- 2) bedtime medication or sedatives (a white card).

The red color on any card facilitates the entry in the daily use records of any narcotic or controlled drug.

Mar. 5/72	3 Hosp.
Bob Brown	
Digoxin 0.25 mg	
$\dot{T}$ q A.M.	
x 7 days.	

GREEN

Mr. Bob Brown - in 3 Hospital  
 Digoxin 0.25 mg.

$\dot{T}$  daily in A.M.  
 x 7

This order requires only 1 green card as it is a once daily medication.

Mar. 5/72 1 Hosp.

Ted Wright

Largactil 25 mg

T BID

x 3 days

GREEN

Mar. 5/72 1 Hosp.

Ted Wright

Largactil 25 mg

T BID

x 3 days

BLUE

Mr. Ted Wright - 1 Hospital  
Largactil 25 mg.  
BID  
x 3 days

2 cards - green card A.M.  
- Blue card P.M.

Mar. 5/72 11

Bill Jones

Tetracycline  
250mg

1 TID

x 6 days

GREEN

Mar. 5/72 11

Bill Jones

Tetracycline  
250mg

1 TID

x 6 days

YELLOW

Mr. Bill Jones - Corridor 11  
Tetracycline 250 mg.  
tid x 6 days

2 cards - green card A.M.  
- yellow card - a tid  
(3 times daily)  
medication

Mar. 5/72 2C

Tom Smith

Penicillin  
500,000 units

1 QID

x 4 days

GREEN

Mar. 5/72 2C

Tom Smith

Penicillin  
500,000 units

1 QID

x 4 days

YELLOW

Tom Smith - Corridor 2C  
Penicillin 500,000 units  
qid x 4 days

2 cards - green card A.M.  
- yellow card - qid  
(4 times daily)

If any of the above orders are for a narcotic or control drug, the card is prepared in the same way but the corner is notched with a red mark as illustrated following:

Mar. 5/72 2X  
Bob Green  
Phenobarbital  
30mg  
1 BID  
x 7 days

GREEN

Mar. 5/72  
Bob Green  
Phenobarbital  
30mg  
1 BID  
x 7 days

RED

Bob Green - 2 annex  
Phenobarb 30 mg. BID  
x 7 days

2 cards - green card A.M.  
- red card P.M.

but corners are notched  
red to indicate control  
drug.

Mar. 5/72 1 Hosp  
Bill Cox  
A.C.&C. 30mg  
1 TID  
x 7 days

GREEN

Mar. 5/72 1 Hosp  
Bill Cox  
A.C.&C. 30mg  
1 TID  
x 7 days

YELLOW

Bill Cox - 1 Hospital  
AC & C 30 mg (292's)

$\frac{1}{T}$  tid  
x 7 days

2 cards - green card - A.M.  
- yellow card - a tid

but again corners are notched  
red to indicate narcotic drug.

NIGHT MEDICATION: 1 white card only; if a narcotic or control drug the  
corner is notched red.

Terry Scott - Corridor 2A  
Noludar 300mg

1 qhs  
x 7 nights

Jim Smith - 2 Annex  
Tuinal 100mg

1 qhs  
x 7 nights

Mar. 5/72 2A  
Terry Scott  
Noludar 300mg  
1 qhs  
x 7 nights

Mar. 5/72 2 Annex  
Jim Smith  
Tuinal 100mg  
1 qhs  
x 7 nights



Mechanics:

There are two trolleys:

- 1) The first is strictly for the green cards - A.M. medications, and
- 2) The second trolley for the second dose of the BID, the second and third dose of tid, the second, third and fourth dose of the qid and the HS meds.

The cards are always arranged in a systematic and orderly fashion according to the patient's location or area.

At the beginning of the day - arrange the cards as follows:

- 1) all the green cards (A.M.) medications in one trolley
- 2) all blue cards (P.M.) medications in the second trolley - plus the H.S. medications (white cards).
- 3) this leaves the yellow cards (tid or qid) - which are arranged separately and prepared for a distribution at noon. These are distributed by the nurse, returned to pharmacy - where the pharmacist then refills the yellow cards again - with one cup for a tid medication distributed at supper hour and then at bedtime. These are worked in the proper area and locations in the second trolley with the blue cards.

This illustrates a 24 hour coverage prepared by the pharmacist and distributed by the nurse and how medicine is controlled over the 24 hour period.

Once the medications are prepared and before distribution, the pharmacist must make all narcotic and control drug usage entries in the control ledgers.

The nurses before distribution check the medication as a double check to prevent medication errors. Tablets which are crushed are identified by color - and the empty capsules, which have been opened and emptied, are left in the cup. Liquid preparations - antacids, cough preparations, laxatives, or ointments, are prepared by the nurse just before distribution.

This system of dispensing medications can be adapted to any institution, be it large or small. If smaller, part-time pharmacist could be used rather than a full-time pharmacist. The use of a pharmacist relieves the duty of a nurse who can spend more time in patient care rather

than dispensing which is a duty of a pharmacist. With proper help, medication errors can be reduced, proper control and security is maintained over all drugs, including narcotic and controlled drugs where perpetual inventories are maintained.

The pharmacist should:

- 1) dispense, distribute and control all drugs;
- 2) purchase and store all drugs;
- 3) maintain records as required by Federal and Provincial laws;
- 4) be an information centre on pharmaceuticals and matters pertaining to the handling and administration of drugs.

(Signed)

C.J. TAI, B.Sc. Phm.,  
Pharmacist,  
Toronto Jail.

April 10, 1972.

THE MEDICAL COLLEGE AND PRISON HEALTH CARE

The Datagram in the July 1972 issue of the Journal of Medical Education noted that in recent years medical school activities in providing health services under contract and in the operation of community health centres and clinics have grown exponentially. One of the programs falling in this category is the provision of health services to penal institutions. Heretofore, relatively little attention has been directed towards the relationships between medical schools and prisons except perhaps in the area of contributions by prisoners to drug studies and clinical research. A greater interest in these relationships is now beginning to emerge. In the aftermath of the 1971-72 disturbances at several penal institutions, public sensitivity towards the issue of the welfare of the almost 300,000 inmates in the nation's penitentiaries, prisons, and jails has greatly heightened. In the spring of 1972 the Association of American Medical Colleges, in response to a request by the Commonwealth Fund, conducted a survey of its constituents to learn the extent of the involvement by medical schools in prison medical care and health matters.

Current Activity of Medical Schools

A total of 54 medical schools (36 state-owned and 18 private institutions) of the 103 which responded to the questionnaire indicated that they were providing health care services to a state prison or local detention centre. The types of services were separated into three categories: general medical-surgical, psychiatric, and rehabilitative (drug addiction, alcoholism, etc.). Of the 54 institutions involved in these kinds of care, 32 were providing service in more than one category, principally general medical-surgical and psychiatric. Of the remaining 22 schools, 15 were involved in medical-surgical services only. Table 1 illustrates the number of schools in each category.

Location of Services

The locus of the health services is an important aspect of the prison medical school arrangement. Costs for treating prisoners in an extra-penitentiary setting involve two singularly high charges: security personnel such as the guards who accompany the prisoners and the special detention construction needed in the health care facility. Balanced against this expense is the cost of maintaining health resources in the prison itself with attendant personnel and overhead expenses. Usually, the size of the prison census and the

availability of prison space will determine which arrangement is employed. Estimates are that approximately half of the prison facilities lack medical facilities in situ on a national basis.

In 65 percent of the medical school prison health care arrangements, the patients are transported to the medical school or its teaching hospital campus. In comparison, 18 percent of the schools normally use both inpatient and outpatient facilities which are in the prison compound. The remainder vary according to whether inpatient (13 percent) or outpatient services (four percent) alone are available in the prison compound.

#### New Interest by Medical Schools

Interfacing with the AAMC questionnaire dealing with the interest and activity on the part of the medical school officials is the American Medical Association-American Bar Association survey of 4,000 state, county, and municipal detention centers on the quality of health care provided. The respondents to the AMA-ABA survey indicated a need for the kind of health care resources which a medical school can offer. At a minimum, these resources should include health planning for the environmental well-being of the inmates, direct health services during the terms of imprisonment, arrangements for follow-up of chronic conditions after institutional release, and the training of health personnel to serve on the premises.

The AAMC survey also revealed that, in addition to the 54 medical schools actively engaged in prison health care, 29 other medical schools (12 state-owned and 17 private institutions) were interested in participating in a service program if adequate funding were available.

An evaluation of the 54 medical school-prison arrangements now in effect to assess which portions of the programs are most suitable for adoption by other medical school-prison settings appears to be needed. An examination of further medical school-prison health care arrangements at state and local levels where such potential exists also would appear to be a constructive step in improving the conditions of prison life.

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TABLE 1

NUMBER OF MEDICAL SCHOOLS PROVIDING VARIOUS  
TYPES OF HEALTH CARE IN PRISONS

<u>Type of Service</u>	<u>No. of Medical Schools</u>
<u>Multiple</u>	
Medical-Surgical, Psychiatric, and Rehabilitative	11
Medical-Surgical and Psychiatric	17
Medical-Surgical and Rehabilitative	2
Psychiatric and Rehabilitative	<u>2</u>
Total	<u>32</u>
<u>Single</u>	
Medical-Surgical	15
Psychiatric	4
Rehabilitative	2
(Unidentified)	<u>1</u>
Total	<u>22</u>

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